CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

WP 23007

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES ☐ NO ☒

12 DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B.	C.
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ] To be sold as scrap or waste paper	☒ To be Burned or shredded	☐ Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS: 2 negative Rolls

C P Force Records Management Officer 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

KP 23007

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69331

CERTIFICATE OF DEATH.

90

D69331

REGISTERED NO.

1-PLACE OF DEATH Municipal Hospital

CITY OF BALTIMORE: (No. Bay View ST., No. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Hanson

(a) RESIDENCE NO. (Usual place of abode) Poor House (Eastern Ave.) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 57 — Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: ? Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hosp. Records (Address)

15 Filed NOV 20 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1922

17

I HEREBY CERTIFY, That I attended deceased from 11-12-, 1922, to 11-18, 1922, that I last saw h alive on Nov. 18, 1922, and that death occurred, on the date stated above, at 2:15 m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No - Reported

What test confirmed diagnosis?

(Signed) Clyde Emrich, M. D.

11/19/22 19 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: Nov. 19 1922

20 UNDERTAKER: E. J. Fanning & Son — ADDRESS: 410 Battery Ave.

Spec.—1-10-21—M&T—1500 Bks.

D69332 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 113 D69332

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 Cerial Str ST. 25 WARD)

2-FULL NAME Alfred (Snyder) Schneider

(a) RESIDENCE No. 28 Cerale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Aug 8, 1922

7 AGE — Years: ..... Months: 3 Days: 10 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED ✓

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Chas. Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Mary Krastnea

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Chas. Schneider
(Address): 28 Cereal St.

15 FILED NOV 20 1922 ROBERT R. KRAUTER, Registrar
NOV 20 1922 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1922 to Nov 16, 1922; that I last saw h— alive on Nov 18, 1922; and that death occurred, on the date stated above, at 3 9. m.

The CAUSE OF DEATH* was as follows: Gastro Enteritis

(duration) yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. 2/2 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Geo D. Horka, M. D.

Nov 19, 1922 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem

DATE OF BURIAL: Nov 20 1922

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1422 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Davage ✓

D69333 HEALTH DEPARTMENT—CITY OF BALTIMORE D69333

141

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 Argyle Ave. WARD) 17

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith C. Davage

(a) RESIDENCE. No. 1136 Argyle Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of George E. Davage

6 DATE OF BIRTH (month, day, and year) JUNE 14-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER George Addison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Addison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Roland L. Davage (Address) 1136 Argyle Ave.

15 Filed ....., 19 ..... Registrar

ROBERT R. KRAUTER Burial Permit Clerk.

776103 NOV 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1922

17 I HEREBY CERTIFY, That I attended deceased from November 5 1922, to Nov 15 1922, that I last saw h[er] alive on Nov 15 1922, and that death occurred, on the date stated above, at 10.15 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilation (Valvular)

(duration) Protracted yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) Protracted yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. Bennett Fargo, M. D.

, 19 (Address) 746 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-21 1922

20 UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69334

CERTIFICATE OF DEATH.

D69334

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5216 (St.) Florence Ave (WARD) 27

2-FULL NAME Gordon Russel Morgan

(a) RESIDENCE NO. 5216 Florence Ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 14, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER J. Calvin Morgan

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillie A. Russell

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Calvin Morgan
(Address) 5216 Florence Ave

15 Filed NOV 20 1922 ROBERT R. KRAUTER, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1922, to Nov 18, 1922

that I last saw him alive on Nov 18, 1922

and that death occurred, on the date stated above, at 10.30A m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Signs

(Signed) Walter Cox M. D.

11/19 1922 (Address) 543 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Nov. 21 1922

20 UNDERTAKER — ADDRESS

Mc Mahon & Anderson, 701 W. Lanvale St.

match should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.--1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69335

CERTIFICATE OF DEATH.

90 D69335

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 Thames ST. 3 WARD)

2-FULL NAME Bernard T. Rolfes

(a) RESIDENCE NO. 1510 Thames ST., 3 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Rolfes

6 DATE OF BIRTH (month, day, and year) Nov. 14 th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	75		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Wright

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn Md. U.S.A.

PARENTS

10 NAME OF FATHER Anton B. Rolfes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary A. Tolford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary E. Rolfes (Wife)

(Address) 1510 Thames St

15 Filed ..... 19 ..... Registrar

NOV 20 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 th 19 22

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 - 19 22 to Nov 17 19 22

that I last saw him alive on Nov 17 19 22

and that death occurred, on the date stated above, at 11 45 p. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis.

(duration) yrs. 3/2 mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) Jno. Chew Bladen M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. — DATE OF BURIAL Nov 21 st 19 22

20 UNDERTAKER Lilly & Zeiler — ADDRESS 403 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69336

D69336

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanley Grady

(a) RESIDENCE NO. Savage Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1913

7 AGE Years 9 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Grady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not Know

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " " "

14 Informant Wm. Grady (Address) Savage Md

15 Filed NOV 20 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-20-1922

17 I HEREBY CERTIFY, That I attended deceased from 11-18, 1922, to 11-20, 1922, that I last saw him alive on 11-20, 1922, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Meningococcus Meningitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Failure - pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Savage, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal punct - Laboratory tests

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Savage Md. DATE OF BURIAL Nov 23 1922

20 UNDERTAKER Geo E French ADDRESS Laurel

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69337

D69337

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 3529 Sweetair ST.: 13 WARD)

2-FULL NAME Gerald Paul Baker

(a) RESIDENCE. NO. 3529 Sweetair ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓	✓	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George D Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Daisie Babylon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George D Baker
(Address) 3529 Sweetair St

15 Filed , 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20th 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct 24th, 1922, to Nov 20th, 1922, that I last saw him alive on Nov 19th, 1922, and that death occurred, on the date stated above, at 4.00 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis.

(duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. 26 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. A. Levitt, M. D.

Nov. 20 1922 (Address) 1 N Gay & Union Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Nov 21 1922

20 UNDERTAKER Chenoweth & Son ADDRESS 1 East Chestnut Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D.69338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.69338

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 N Payson ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Carll Woodhull

(Residence in Baltimore: No. 504 N. Payson St.; 14 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widowed

6-DATE OF BIRTH. Feb (Month) 20 (Day), 1853 (Year)

7-AGE, 69 yrs. 8 mos. 30 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ship Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Nelson Smith Woodhull

11-BIRTHPLACE OF FATHER (State or Country), New York

12-MAIDEN NAME OF MOTHER Mary E. Davis

13-BIRTHPLACE OF MOTHER (State or Country), New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carll M. Woodhull

(Address) 504 N. Payson St

15-

Filed....., 191.....

Robert E. Harrison, Registrar.

NOV 20 1922 Social Purity Clerk.

MEDICAL CERTIFICATE OF DEATH. for Mr. Clarence C. Woodhull, 504 N. Payson.

16-DATE OF DEATH, November (Month) 19th (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12 1922 to Nov. 19th 1922, that I saw h[im] alive on Nov. 19th 1922, and that death occurred, on the date stated above, at 12:15 a.m.

The CAUSE OF DEATH* was as follows:

Congestion of lower lobe of left lung, developing into left lobar pneumonia (See remarks)

(Duration) 1 yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(Duration) uncertain yrs. mos. ds.

(Signed) O. H. Hoffman M. D.

Nov. 19th, 1922 (Address) 3402 Walbrook Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, River Head - Long Island via Penn RR — DATE OF BURIAL, Nov. 21, 1922

20-UNDERTAKER John F. Denny — ADDRESS 715 Light St

IMPORTANT. AGE should be stated in YEARS, MONTHS or DAYS, whichever is correct. Every item should be filled in very carefully. PHYSICIANS should be particular to see that CAUSE OF DEATH is properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69339

D69339

CERTIFICATE OF DEATH.

36-005

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., 10 WARD)

2-FULL NAME Albert A. Hoffman

(a) RESIDENCE NO. 815 Asquith St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 5th 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maryland Water Works

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Albert L. Hoffman

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Elmira Sheridan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant (Address) Albert L Hoffman 2231 Hennemen Ave

15 Filed Nov 23 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19th 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15 1922 to Nov 19 1922 that I last saw him alive on Nov 19 1922 and that death occurred, on the date stated above, at 12 20 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Tubercular Osteitis of Spine (duration) yrs. 8 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X ray.

(Signed) J. Schamberg, M. D.

19 (Address) St Jos. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Nov 22nd 1922

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

20 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69340

D69340

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3323 Eastern ave ST., 76 WARD)

2-FULL NAME Lillian F Senger

(a) RESIDENCE NO. 3323 Eastern ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) February 20 1922

7 AGE — Years: — Months: 8 Days: 30 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): 66

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William J Senger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Madalena Krebs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): William J Senger 3323 Eastern ave

15 Filed ....., 19 ..... Registrar: Robert P. Garrison,

NOV 20 1922 ~~Burial Permit Clerk~~.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-19 1922

17 I HEREBY CERTIFY, That I attended deceased from 11-13-22, 19 22 to 11-19, 19 22

that I last saw her alive on 11-19, 19 22

and that death occurred, on the date stated above, at 6.55 P.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Pleurisy acute

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Cerebral Catarrh

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J Fred Dunfield, M. D.

19 22 (Address) 700 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Nov 21st 1922

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69341

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69341

CERTIFICATE OF DEATH.

112

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2903 Dillon ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis D Hartman

(a) RESIDENCE NO. 2903 Dillon ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 17-1918

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or .... min.
4		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Margaret Bast

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Mrs. Margaret Hartman 2903 Dillon St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1922, to Nov 19, 1922, that I last saw her alive on Nov 18, 1922, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows: Chronic Gastritis

(duration) yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A A Dean M. D.

Nov 20. 1922 (Address) 2600 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Nov 21 1922

20 UNDERTAKER Bus C Miller

ADDRESS 2334 Jeffers St

Registration should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

20 1922

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69342

D69342

CERTIFICATE OF DEATH.

REGISTERED NO. C 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 N. Bradford ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophie Bartosek

(Residence in Baltimore: No. 815 N. Bradford St.; 70 yrs., mos., ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOW(ER), OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 61 yrs. mos. ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Bohemia

PARENTS.

10-NAME OF FATHER, Karl Conrad

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Sophie Jendra

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Karl Conrad

(Address) 815 N. Bradford

15-

Filed ....., 191.....

Registrar.

NOV 20 1922 Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 19, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22 1922, to Nov 19 1922,

that I saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Goshe C. Disease

.....

..... (Duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wilbur H. Jones M. D.

Nov. 20, 1922 (Address) 80 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	Nov. 21., 1922
20-UNDERTAKER	ADDRESS
[illegible]	906 Carroll Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69343

CERTIFICATE OF DEATH.

164

D69343

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 3504 Elliott St. N. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christian Schumpf

(Residence in Baltimore: No. 3504 Elliott St.; 5.0 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White	Widower

6-DATE OF BIRTH, June 21st, 1831.
(Month) (Day) (Year)

7-AGE, 90 yrs. 4 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Barber

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Geo Schumpf

(Address) 3504 Elliott St.

15-

Filed....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

NOV 20 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 18, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1922, to Nov 18 1922, that I saw h— alive on Nov 18 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Horace B. Tyson M. D.

Nov 19, 1922 (Address) 315 S. Highland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel

DATE OF BURIAL, Nov 21st, 1922

20-UNDERTAKER Peter Nicolaus & Co

ADDRESS Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69344 D69344

CERTIFICATE OF DEATH

101-001

1-PLACE OF DEATH (City) REGISTERED NO. C

CITY OF BALTIMORE: (No. 613 West Ave St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Hartman Sr

(Residence in Baltimore: No. 613 West AVE St.; 64 yrs., — mos., — ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug 15, 1858 (Month) (Day) (Year)

7-AGE, 64 yrs. 3 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Iron Moulder
(b) General nature of industry, business, or establishment in which employed (or employer) at S B Sexton Co

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Hartman

(Address) 613 West Ave

15- Burial Permit Clerk

Filed ....., 191.... Registrar.

NOV 20 1922 Robert P. Hartman

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 19, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 12 1922, to Nov. 19 1922, that I saw him alive on Nov. 19 1922, and that death occurred, on the date stated above, at 5-30 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ... yrs. ... mos. ... ds.

(Signed) Elmer L. Heer M. D.

11/20/22, 191... (Address) 405 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Parkwood Ceme

DATE OF BURIAL, Nov 22, 1922

20-UNDERTAKER Peter Nicolaus

ADDRESS 2000 Eastern Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69345 D69345

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 N. Carrollton Ave ST.: 18 WARD)

2-FULL NAME Charlotte V. Thomas

(a) RESIDENCE. No. 117 N. Carrollton Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 21, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13.	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wilmer Thomas.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ora Bunn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Ora Bunn Mastz
(Address) 117 N. Carrollton Ave

15 Filed..... 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1922. to Nov. 18, 1922.
that I last saw her alive on Nov. 13, 1922.
and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary test & Clinical Symptoms.

(Signed) Edwin N. Baumbaker, M. D.

19 (Address) 1209 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Nov. 21 19[illegible]

20 UNDERTAKER George J. Smith — ADDRESS 1832 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should s
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

NOV 20 1922

Spec.—6-9-19—H. P. Co.—1000 Blks.

D69346

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69346

CERTIFICATE OF DEATH.

89

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 611 Haywood Ave ST.: 27 WARD)

2-FULL NAME Hanson W. Gillespie

(a) RESIDENCE. NO. 611 Haywood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PAY ... should be stated EXACTLY. PHYSICIANS ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 ~~Single~~, Married, ~~Widowed, or Divorced (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma E. Gillespie

6 DATE OF BIRTH (month, day, and year): July 18, 1853

7 AGE — Years: 69 Months: 4 Days: 1 If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wm Gillespie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Anna Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Emma E. Gillespie
(Address) 611 Haywood Ave

15 Filed ... 19 ... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/19 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 16th, 1922, to Nov 19th, 1922, that I last saw ~~him~~ alive on Nov 18th, 1922, and that death occurred, on the date stated above, at 10.00 A. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pleurisy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W. R. Leeper, M. D.

Nov 19 1922 (Address) 614 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Nov. 21 1922

20 UNDERTAKER: George J. Smith

ADDRESS: 1006 W. Pratt St.

Spec.—1-10-21—M&T—1500 Blks.

D69347

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69347

CERTIFICATE OF DEATH.

8 X 31

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

CITY OF BALTIMORE: (No. Fort McHenry, Baltimore, Md ST., WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ASTON, George

(a) RESIDENCE NO. 2302 E. North Ave., Baltimore, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): --

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	27	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Miner

(b) General nature of Industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): -- Alabama

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records

(Address): Fort McHenry, Md.

15 Filed ... 19 ... Registrar

Robert F. Hartman, Deputy Permit Clerk.

NOV 20 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 17 19 22.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13 .19 22. to Nov. 17 .19 22.

that I last saw him alive on Nov. 17 .19 22.,

and that death occurred, on the date stated above, at 6:35 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic, Far Advanced & Active.

Unknown (duration) - yrs. - mos - ds.

CONTRIBUTORY (Secondary) --

-- (duration) -- yrs. -- mos. -- ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical history

(Signed) H. H. Banks Surgeon (R) M. D.

11/18 22 (Address) Ft. McHenry, Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery

DATE OF BURIAL: 11/20 1922

20 UNDERTAKER: S. Levinson & Bro

ADDRESS 224 E. Balto St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Dobrostow)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69348

CERTIFICATE OF DEATH.

188-003 D69348

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vladymir Dobrostow

(Residence in Baltimore: No. 509 S. Regester St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 28 (Day) 1916 (Year)

7-AGE, 6 yrs. 3 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Anastazy Dobrostow

11-BIRTHPLACE OF FATHER, (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Jones Zacharko

13-BIRTHPLACE OF MOTHER, (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anston Dobrostow

(Address) 509 S. Regester St

15-

Filed ..... 192.....

Robert P. [illegible]
Burial Permit Clerk.
Registrar.

NOV 20 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 18 (Day) 192? (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident — Struck by automobile

Skull — Internal Injuries

Shock (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) J. H. Walker M. D.
(Coroner)

11-20 192? (Address) 508 E. Fort Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Nov. 11, 23

20-UNDERTAKER, Wm. Fiallowski — ADDRESS 1618 Eastern

B. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69349 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ D69349

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Parrish ST.: 16 WARD)

2-FULL NAME Levin Henry Pinckney

(a) RESIDENCE. NO. 809 Parrish ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Pinckney

6 DATE OF BIRTH (month, day, and year) Apr. 4th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Common Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md

PARENTS

10 NAME OF FATHER Henry Pinckney

11 BIRTHPLACE OF FATHER (city or town) St. Michaels (State or country) Md

12 MAIDEN NAME OF MOTHER Maggie Hill

13 BIRTHPLACE OF MOTHER (city or town) Balto. City (State or country) Md

14 Informant Mrs. Maggie Pinckney
(Address) 809 Parrish St.

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
NOV 21 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13th 1922, to Nov. 20th 1922, that I last saw h im alive on Nov. 19th 1922, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Miliary ? Tuberculosis

(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) Jas. Carl Hill, M. D.

, 19 (Address) 1324 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 22 1922
20 UNDERTAKER (David Easter.	ADDRESS 416 Ca Ave

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69350 — **CERTIFICATE OF DEATH.** 100-001 — **D69350**

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Penna Ave St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Lee Valentine

(Residence in Baltimore: No. 1605 Penna Ave St.; 2 yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 18, 1920
(Month) (Day) (Year) 1922

7-AGE, 2 yrs. 2 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: 1-20-1923
(a) Trade, profession, or particular kind of work Eleventh mo
(b) General nature of industry, business, or establishment in which employed (or employer) none

9-BIRTHPLACE, (State or Country) Balto City

PARENTS.

10-NAME OF FATHER, James Valentine

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Annie Henderson

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Valentine

(Address) 1605 Penna Ave

15-

Filed NOV 2 1922 191.....

ROBT. R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 1, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 191..., to 191..., that I saw h alive on 191..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Nov 2, 191 2

20-UNDERTAKER Daniel Easter & Son

ADDRESS 916

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

The Mother of Rosa Lee Valentine.

Annie Valentine says her child Rosa Lee
born on Sept 18-1920. instead of Sept 192
Said statement was signed Jan 20-1923.

Signed Annie Valent
1605 Pennsylvania
Mother

Witness
George H Gresse

, etc., *Carcinoma, Sar-*
ne origin; "Cancer" is
'Tumor' for malignant
oping cough; Chronic
nic interstitial nephritis;
ndary or intercurrent)
unless important. Ex-
using death), 29 *ds.*;
ary), 10 *ds.* Never re-
inal conditions, such as
ly symptomatic), "Atro-
, "Convulsions," "De-
nile," etc.), "Dropsy,"
e," "Haemorrhage," "In-
l age," "Shock," "Ure-
en a definite disease can
e. Always qualify all
dbirth or miscarriage, as
'PUERPERAL *peritonitis*,"
surgical operation was
DEATHS state MEANS OF
DENTAL, SUICIDAL, HOMI-
, if impossible to deter-
: *Accidental drowning;*
cident; Revolver wound
ned by carbolic acid—
re of the injury, as frac-
nces (*e. g., sepsis, teta-*
the head of "Contribu-

ned for additional infor-
the following diseases,
sole cause of death:

Childbirth, Convulsions,
Erysipelas, Meningitis,
Necrosis, Peritonitis,
Septicæmia, Tetanus.

eferred to a Coroner:

(if criminal negligence
s, Homicides, Abortions
is directly or indirectly

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69351 38 **D69351**

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 756 Waesche ST., 4 WARD)

2-FULL NAME Anna Bell Bowman

(a) RESIDENCE NO. 756 Waesche ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE: 42 Years | Months | Days | If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS
10 NAME OF FATHER: John Wilson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't Know
12 MAIDEN NAME OF MOTHER: Martha Wilson
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: John Mussy
(Address): 756 Waesche St

15 Filed NOV 21 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1922, to Nov 18, 1922, that I last saw h alive on Nov 18, 1922, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary): Probably Cystitis ?
(duration) un known yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) R B Kempton M. D.

11/[illegible] 1922 (Address) 607 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 11-21 1922

20 UNDERTAKER: David Easton — ADDRESS 916 [illegible]

N. B. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Floyd J. Boone

15 D69352

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 41 D69352

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Floyd J Boone

(a) RESIDENCE No. Easton Md ST., WARD

(Usual place of abode) Talbot Co. (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1914

7 AGE: Years 8 years; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton, Md Talbot Co

PARENTS

10 NAME OF FATHER James Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton Md

12 MAIDEN NAME OF MOTHER Mary Travers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed NOV 21 1922, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20, 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1922. to Nov. 20, 1922.

that I last saw him alive on Nov. 20 1922,

and that death occurred, on the date stated above, at 8 40 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis, Septicaemia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Septicaemia, postoperative

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 17, 1922

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R. E. Leyhard, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Maryland — DATE OF BURIAL: Nov 21 1922

20 UNDERTAKER: Joseph Ahern — ADDRESS: 2218 Way

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Ankylosis - Streptococcus Infection.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69353

CERTIFICATE OF DEATH.

X 139. D69353

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne M. Hull

(a) RESIDENCE NO. 21 Groveland Terrace ST., Minneapolis, Minn. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Louis H. Hull

6 DATE OF BIRTH (month, day, and year): Sept 22-1865

7 AGE: Years 57 Months 1 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Minnesota

PARENTS

10 NAME OF FATHER: Tom. McMain

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ky.

12 MAIDEN NAME OF MOTHER: Hodie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: JOHNS HOPKINS HOSPITAL (Address)

15 Filed NOV 21 1922 ROBERT R. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1922, to Nov. 20, 1922, that I last saw her alive on Nov. 20, 1922, and that death occurred, on the date stated above, at 4.35 P.m.

The CAUSE OF DEATH* was as follows:

Acute cardiac failure, Angina.

(duration) — yrs. — mos 12 hours ds.

CONTRIBUTORY (Secondary) Operation four days previously. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 17, 1922.

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs.

(Signed) Karl H. Mayfield, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Minneapolis Minn — DATE OF BURIAL: Nov 21 1922

20 UNDERTAKER: John C. Mitchell — ADDRESS: 1201 W. Fayette

N. B. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Myocardial degeneration,
Uremia

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69354

CERTIFICATE OF DEATH.

101-001 D69354

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #238-N-Carey-St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARY MAY LEES

(a) RESIDENCE NO. #238-N-Carey-St. ST., 19 WARD (Resident)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? 55 yrs. 5 mos. 13 ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT record. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) June-6-1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Public School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Teacher. (Balto.)

(c) Name of employer City of Baltimore.

9 BIRTHPLACE (city or town) Millington, (State or country) Kent Co., Md.

PARENTS

10 NAME OF FATHER James M. Lees.

11 BIRTHPLACE OF FATHER (city or town) Phila. (State or country) Penna.

12 MAIDEN NAME OF MOTHER Emily V. Longfellow

13 BIRTHPLACE OF MOTHER (city or town) Millington (State or country) Kent Co., Md.

14 Informant Wm. G. Lees (brother)

(Address) 238-N-Carey-St., City.

15 Filed NOV 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1922 to Nov 19, 1922

that I last saw h[illegible] alive on Nov 19, 1922

and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? [illegible] Washington

Did an operation precede death? No Date of Not

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) John A. Dean M. D.

, 19 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Millington, Kent Co., Md. DATE OF BURIAL: Nov-22-22

20 UNDERTAKER: STEWART & MOWEN COMPANY, WILLIAM F. WOODER, Successor ADDRESS: 108 W. NORTH AVE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69355

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

188-003

D69355

Registered No. C.....

City of BALTIMORE: (No. Mercy Hospital St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME GABRIEL DuVAL

(Residence in Baltimore: No. 1226-N-Calvert St. (11-Ward) St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. July (Month) 30 (Day) 1852 (Year)

7-AGE. 70 yrs. 3 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Hicks-Taste-Norris.

9-BIRTHPLACE, (State or Country): Maryland

PARENTS:

10-NAME OF FATHER. Edmund Brice

11-BIRTHPLACE OF FATHER, (State or Country) Prince Geo. Co., Md.

12-MAIDEN NAME OF MOTHER, Caroline Lansdale

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Clover G. DuVal, (wife)

(Address) 1226-N-Calvert-St. City

15- Filed NOV 21 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 18 (Month) (Day) 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull
Fract Rib
Internal Hemorrhage
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
Nov. 20 1922 (Coroner) (Address) [illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death 0 yrs. 0 mos. 0 ds. In the State 70 yrs. 3 mos. 18 ds.

Where was disease contracted, if not at place of death?
Mt. Royal Av., near Calvert St.
Former or usual residence 1226-N-Calvert-St

19-PLACE OF BURIAL OR REMOVAL, Hillmeade Prince Georges Co. Md. DATE OF BURIAL, Nov 21 1922

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Calia K Trawinski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69356

CERTIFICATE OF DEATH.

3/V

D69356

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2107 Ese ST., 1 WARD)

2-FULL NAME Calja Kausek Trawinski

(a) RESIDENCE NO. 2107 Ese ST., 1 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 8 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanislaus Trawinski

(Address) 2107 Ese St

15 Filed NOV 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 28 1922 to Nov 19 1922

that I last saw h alive on Nov 19 1922

and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

Nov 21 1922 (Address) 801 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem — DATE OF BURIAL Nov 22 1922

20 UNDERTAKER Stephen J Kwiatkowski — ADDRESS 1001 Hanover

N. B. Blanks should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69357

D69357

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 Reach St.: 22 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Stevens

(a) RESIDENCE. No. 811 Reach al St., — Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Stevens

6 DATE OF BIRTH (month, day, and year) Sept 16, 1869

7 AGE	Years	Months	Days	If LESS than 1 day: hrs. or min.
	53	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) B. W. I.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) B. W. I.

14 Informant Bertha Stevens

(Address) 811 Reach St

15 Filed NOV 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/19/1922

17 I HEREBY CERTIFY, That I attended deceased from 10/16/, 1922, to 11/19/, 1922, that I last saw h[illegible] alive on 11/19/, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

Lobar

Suprocute Nephritis

Pneumonia

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) about yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical - Symptoms

(Signed) J. Lang Mosley M. D.

11/19/22 (Address) 405 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 21 1922
20 UNDERTAKER	ADDRESS
A. H. Brown & Son	1080 W. Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D69358

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D69458

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 Madison Ave. St. 14 WARD)

2-FULL NAME Leopoldina Kann.

(a) RESIDENCE NO. 1630 Madison St. Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mendel Kann

6 DATE OF BIRTH (month, day, and year): March 8 1847.

7 AGE	Years	Months	Days	11 LESS than 1 day, hrs. or min.
	75	8	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Meyer Neuberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Adeline Fradberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Dr. B. Bar 1630 Madison Ave.

15 Filed NOV 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/20/1922

17 I HEREBY CERTIFY, That I attended deceased from Aug, 1922, to Nov, 1922, that I last saw h[illegible] alive on Nov 19, 1922, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 0 yrs. 5 mos — ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic examination

(Signed) Harry Adler, M. D.

, 19 (Address) 1718 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem.

DATE OF BURIAL: 11/22/1922

20 UNDERTAKER: David Sondheim

ADDRESS: 1180 W. Mt. Royal Ave.

N. B. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69359

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69359

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 Washington Blvd WARD 22)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl L. Sellinger

(a) RESIDENCE NO. 531 Washington Blvd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 22 1922

7 AGE: Years — Months 1 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Earl Sellinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Depner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Earl Sellinger

(Address) 531 Washington Blvd

15 Filed NOV 2 1922 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 1 - 1922, to Nov 20 1922

that I last saw alive on Nov 20 1922

and that death occurred, on the date stated above, at 4-10 m. pm

The CAUSE OF DEATH* was as follows:

Congenital debility

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary): Premature birth weight 4 lbs

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Sellinger M. D.

11-20 1922 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Nov 21 1922

20 UNDERTAKER: Jos Joerdens Son

ADDRESS: 2178 Bo

N. B. All items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69360

CERTIFICATE OF DEATH.

D69360

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Wolfe (Gaudenville) ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Ritche

(Residence in Baltimore: No. 8 Wolfe ave (Gaudenville) St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Married

6-DATE OF BIRTH, Dec 20, 1846
(Month) (Day) (Year)

7-AGE, 76 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home work
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Not Known

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Ritche

(Address) 8 Wolfe ave

15- NOV 2 1922 ROBERT R. KRAUTER, Burial Permit Clerk
Filed....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 19, 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Oct 3 1922, to Nov 19 1922, that I saw h e alive on Nov 18 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH was as follows:

Chronic Pneumonia

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bed sores

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. D. Yeagy M. D.

Nov 1, 1922 (Address) Cor E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery — DATE OF BURIAL. Nov 22, 1922

20-UNDERTAKER Henry Storck Son — ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69361

CERTIFICATE OF DEATH.

10

D69361

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 Anthony ST., 10 WARD)

2-FULL NAME Gertrude Dorothy Schmitt.

(a) RESIDENCE NO. 1413 Anthony ST., 10 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Octo 27 1919

7 AGE — Years: 3 — Months: — — Days: 23 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 822

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Andrew J. Schmitt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Dorothy E. Mark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mr. Andrew J. Schmitt.
(Address) 1413 Anthony St

15 Filed NOV 2 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 19 22, to Nov. 20, 19 22, that I last saw her alive on Nov 20, 19 22, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Acut Heart Failure

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary): Deptheria.

(duration) ..... yrs. ..... mos. 9. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Culture

(Signed) C. N. Meyer Jr. M. D.

(Address) 2638 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Nov. 25 19 22

20 UNDERTAKER: Henry Storck Son — ADDRESS: 1301 E Lafayette

N. B.—WHITE PENCIL, WHITE STAMPS. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69362

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69362

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 E. Eager St. ST., 10 WARD)

2-FULL NAME Mary. M. Gassinger

(a) RESIDENCE NO. 1407 E. Eager ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. August. A. Gassinger

6 DATE OF BIRTH (month, day, and year) March-16-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Francis Schandelle

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Mr. August. A. Gassinger (Address) 1407 E. Eager St.

15 Filed NOV 21 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov.-20-1922

17 I HEREBY CERTIFY, That I attended deceased from November 19 22 to November 20 22

that I last saw h[illegible] alive on November 20 19 22

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What tests confirmed diagnosis? Clinical

(Signed) Walter A. Negus M. D.

11/21, 19 22 (Address) 1021 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Nov-23 19 22

20 UNDERTAKER Henry Horch Son

ADDRESS 139 E. Eager St.

N. B.—WRITE PLAINLY, with indelible pencil. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

John Brown

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69363 HEALTH DEPARTMENT—CITY OF BALTIMORE D69363

CERTIFICATE OF DEATH.

90

REGISTERED NO. [redacted]

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 Warner ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Brown

(a) RESIDENCE. NO. 834 Warner ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colord

5 ~~Single~~, ~~Married~~, Widowed, or Divorced (write the word): Widowder

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 62 Years | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: non

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): 834 Warner St Bal md

PARENTS

10 NAME OF FATHER: andre Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Lizzie Odmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant (Address): Lillie Hide 834 Warner St

15 Filed NOV 21 1922, 19 [illegible] Registrar

ROBERT P. KRAUSE
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1922, to Nov 18, 1922, that I last saw h[illegible] alive on Nov 18, 1922, and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows: Cardiac Dema (Valvular)

(duration) — yrs. / mos. ds.

CONTRIBUTORY (Secondary) as Above

(duration) yrs. / mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Symptoms

(Signed) C. K. Horn M. D.

(Address) 712 S Rasp Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Nov 21 1922
20 UNDERTAKER	ADDRESS
John H Faadrun	142 Ashland

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69364

CERTIFICATE OF DEATH.

181-401

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 811 W. Fayette St. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Joseph L. Wesshan

(Residence in Baltimore: No. 811 W. Fayette St. St.; 40 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Don't Know ..... 1.....
(Month) (Day) (Year)

7-AGE. 40 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Sign Painter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Bath Me.

PARENTS.

10-NAME OF FATHER. Michael Hesshan

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country). Orleans

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Murray

(Address) 1625 W Fayette St

15-Filed NOV 21 1922 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 19 (Month) (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Installation of Illuminating Gas

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Accidental

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

11-21 192 (Address) 15 N Sharp St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Peters Cem	Nov 22 1922

20-UNDERTAKER.	ADDRESS
John J Cowan Son	901 Hollins St

Every item of information should be carefully supplied. All items should be plainly entered. Information should be such that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. State CAUSE OF DEATH in plain terms, so that

Space, 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69365

CERTIFICATE OF DEATH.

24

D69365

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 505 N. Norris St., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Josephine Howard

(a) RESIDENCE No. 505 N. Norris ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6th. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Co. Va.

12 MAIDEN NAME OF MOTHER Julia Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Philadelphia Pa.

14 Informant Julia Howard
(Address) 505 N. Norris

15 Filed NOV 21 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/18/'22 19

17

I HEREBY CERTIFY, That I attended deceased from 11/18/'22, 19, to 11/18/'22, 19,

that I last saw her alive on 11/18/'22, 19,

and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 21 19 22
20 UNDERTAKER	ADDRESS 114 or.
Brown Tuland.	Schroder St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Epidemic

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69366

CERTIFICATE OF DEATH.

49 D69366

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 26 WARD)

2-FULL NAME James Spencer

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70 ?	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Philadelphia, Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Municipal Hospital Records

(Address)

15 Filed NOV 2 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 18 1922

17

I HEREBY CERTIFY, That I attended deceased from November 14 1922, to November 18 1922.

that I last saw him alive on November 18, 1922.

and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Obstruction

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

11/18/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: Nov 23 1922

20 UNDERTAKER: Jas. F. Dennis

ADDRESS: 2313 Greenmount

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D69367 ~~2nd Reg~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D69367

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 14 WARD)

2-FULL NAME William Brown

(a) RESIDENCE NO. 1836 McCulloh St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ ?

6 DATE OF BIRTH (month, day, and year) May 30-1872

7 AGE: Years 50 Months 5 Days 14 days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Wm. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Spain

12 MAIDEN NAME OF MOTHER Eliza Gibbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed NOV 21 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1922, to Nov 19, 1922

that I last saw him alive on Nov 19, 1922

and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Gall Bladder c

Liver metastases

(duration) 1 yrs. ? mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Thos. H. Burg M. D.

11/19 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL Nov 21 1922

20 UNDERTAKER Jas. N. Deems — ADDRESS 313 Cathedral

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69368

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69368

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 Homewood Ave ST., 40 WARD)

2-FULL NAME John F. C. Kearney

(a) RESIDENCE NO. 1034 Homewood Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Kearney

6 DATE OF BIRTH (month, day, and year) June 1-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of Industry, business, or establishment in which employed (or employer) Balto Transfer Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Patrick Kearney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margt. Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. Mary Kearney 1034 Homewood Ave

15 Filed NOV 21 1922, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 17, 1922, to Nov 20, 1922, that I last saw ~~him~~ alive on Nov 18 1922 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 1034 Homewood Ave

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Benton, M. D.

11 20 1922 (Address) 700 E Chases

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Nov 23 1922

20 UNDERTAKER W. C. Windfield — ADDRESS 914 Gruman Bldg

NOV 21 1922 ROBERT R. KRAUTER

Spec.—8-24-14—M. & T.—2000 Blks.

Hall

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69369

CERTIFICATE OF DEATH.

74-001

D69369

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1552 Argyle ave. St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane E. Hall

(Residence in Baltimore: No. 1552 Argyle ave. St.; 12 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 1877 (Month) ; 1 (Day) (Year)

7-AGE, 10 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Porter - 610
(b) General nature of industry, business, or establishment in which employed (or employer) Longview

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Joseph Hall

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Martha -

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Hall

(Address) 1552 Argyle ave

15- Filed NOV 2 1922, 191.. HUBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 19th (Month) (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1922 to Nov. 19th 1922 that I saw h[illegible] alive on Nov. 17th 1922, and that death occurred, on the date stated above at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Partially due to arterio

Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

11/21, 1922 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Int. Auburn Cem.

DATE OF BURIAL, 11/22, 1922

20-UNDERTAKER Jas. M. Simms

ADDRESS 1625 E. Mad. st.

D69370 HEALTH DEPARTMENT—CITY OF BALTIMORE D69370

CERTIFICATE OF DEATH.

164

1-PLACE OF DEATH 817 St Johns Court

City of BALTIMORE: (No. Annie A Jones St., 10 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie A. Jones

(Residence in Baltimore: No. 817 St. Johns Court St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. Use words fully; state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Black	Widowed

6-DATE OF BIRTH, March 4, 1847
(Month) (Day) (Year)

7-AGE, 75 yrs. 8 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto Co. Md

PARENTS.

10-NAME OF FATHER, Felix Brown

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Ann Merriman

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daughter

(Address) 817 St Johns Court

15- Filed NOV 2 1922 19.. ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 13, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senile Debility

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Thal Nutrition

(Duration).....yrs.....mos.....ds.

(Signed) J. S. H. Haller M. D.
(Coroner.)

11-20 1922. (Address) 406 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.
JOHNS HOPKINS HOSPITAL 19..

20-UNDERTAKER, Commissioner Health. ADDRESS NOV 2 1922

1967 THE MORGUE.

D69371

D69371

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 Penna Ave ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME F. Harrison Diggs

(a) RESIDENCE. NO. 1527 Penna Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Blanche Diggs

6 DATE OF BIRTH (month, day, and year): Mar. 31/1895

7 AGE — Years: 27 — Months: 8 — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Md.

PARENTS

10 NAME OF FATHER: Fentress Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md.

12 MAIDEN NAME OF MOTHER: Josephine Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Md.

14 Informant: Albert Diggs (Address): Cockeysville Balto Co Md

15 Filed NOV 2 1922, 19 — ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 19 19 22

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1922, to Nov. 19, 1922, that I last saw him alive on Nov. 19, 1922, and that death occurred, on the date stated above, at 11.30A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam

(Signed) Nevin C. Dysart, M. D.

, 19 (Address) 1006 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Piney Grove Cemetery

DATE OF BURIAL: Nov 22 1922

20 UNDERTAKER: Balto Co Md — J. F. Edelin

ADDRESS: Randallstown

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D69372 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D69372

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 S Linwood Ave WARD)

2-FULL NAME Benjamin J Swinson

(a) RESIDENCE NO. 710 S Linwood Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., If of foreign birth? 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widower of Annie M Swinson

6 DATE OF BIRTH (month, day, and year): Sept 6 1857

7 AGE: Years 65 Months 2 Days ..... If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mariner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Norfolk Va

PARENTS

10 NAME OF FATHER: John Swinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norfolk Va

12 MAIDEN NAME OF MOTHER: Hodgson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Norfolk Va

14 Informant (Address): William J Swinson 710 S Linwood Ave

15 Filed NOV 21 1922, 19 ..... ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 20 1922

17 I HEREBY CERTIFY, That I attended deceased from November 15, 1922, to Nov. 20, 1922, that I last saw him alive on Nov 19 1922, and that death occurred, on the date stated above, at 4.45A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Caleb A Athey M. D.

Nov. 21, 1922 (Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Nov 23 1922
20 UNDERTAKER	ADDRESS
William Cook	502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69373 161-001 D69373

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (Twin #2) REGISTERED NO.....

CITY OF BALTIMORE: (No. 2508 Remington ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Lee

(a) RESIDENCE. No. 2508 Remington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 20/22

7 AGE	Years	Months	Days	If LESS than 1 day/0 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Porto Rican

12 MAIDEN NAME OF MOTHER Ida Wicks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington

14 Informant Ida Lee
(Address)

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1922, to Nov 21, 1922.

that I last saw h[illegible] alive on Nov 20, 1922

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth at about 6th month of Pregnancy

Natural Causes

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W Clyde Dyson, M. D.

11-4-22 19 (Address) 2201 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Nov. 21 1922
20 UNDERTAKER	ADDRESS
Theodore E. White	1135 Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 22 1922 Registrar

Burial Permit Issued

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69374

CERTIFICATE OF DEATH. 161-001 Twin #1

D69374

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2808 Remington ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Lee

(a) RESIDENCE. No. 2808 Remington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Col	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 20-22

7 AGE	Years	Months	Days	If LESS than 1 day, 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Lee

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Porto Rican

12 MAIDEN NAME OF MOTHER Ida Wickes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Washington

14 Informant Ida Lee
(Address)

15 Filed ....., 19 ..... Registrar

Robert F. Hartman,
Burial Permit Clerk.

NOV 21 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1922, to Nov 21, 1922

that I last saw h[illegible] alive on Nov 20, 1922

and that death occurred, on the date stated above, at 2 [illegible] m.

The CAUSE OF DEATH* was as follows:

Premature birth at about 6th month. Pregnancy - natural causes

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Clyde Burns, M. D.

11-21 1922 (Address) 2162 Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov 22 1922
20 UNDERTAKER	ADDRESS
Theodore G. Hillit	1130 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69375 D69375

CERTIFICATE OF DEATH.

123

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers of America Hospital ST.: WARD)

2-FULL NAME Cleopatra Wagner

(a) RESIDENCE. NO. 729 W. Lexington ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sylvester Wagner

6 DATE OF BIRTH (month, day, and year) Aug 20 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	3	"	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Beckler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Penn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant (Address) Mrs Sylvester Wagner 729 W. Lexington ste

15 Filed Nov 19 1922 E. Harriman Registrar

NOV 21 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 17, 1922, to Nov 20, 1922, that I last saw her alive on Nov 20, 1922, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Rupture of Gall Bladder

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Surgical Shock

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Nov 17

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) Albert J Comey, M. D.

, 19 (Address) Vol. of Am Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Little Chapel Parnell Via W.B.&A.-A.R.	Nov 22 1922
20 UNDERTAKER John F Dunn	ADDRESS 715 Light

N. B.—WRITE PLAINLY. WITH INK. All the information should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69376

D69376

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 115 Mc Phail ST., 20 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest W. F. Zimmerman

(a) RESIDENCE NO. 115 Mc Phail ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian M. Zimmerman

6 DATE OF BIRTH (month, day, and year) Feb 17 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	35	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Optometrist

(b) General nature of Industry, business, or establishment in which employed (or employer) 1886

(c) Name of employer Boyd & King

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER Rev. George Henry Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary F. Hallinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary F. Zimmerman

(Address) 115 Mc Phail st

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20th 1922

17

I HEREBY CERTIFY, That I attended deceased from ....., 19 ..., to ....., 19 ...

that I last saw her alive on November 15, 1922

and that death occurred, on the date stated above, at 140 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs + mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Edw L Coolahan, M. D.

11/21, 1922 (Address) 24 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 22 1922
20 UNDERTAKER	ADDRESS
Chas. Weber & Son	2503 Edmondson Ave

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

21 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69377

D69377

CERTIFICATE OF DEATH.

52

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 Edmondson Ave ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Heissenbuttel.

(a) RESIDENCE NO. 2015 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Buck

6 DATE OF BIRTH (month, day, and year) Aug 21-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Martin Heissenbuttel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rebecca Hentzen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Heissenbuttel (Address) 2015 Edmondson Ave

15 Filed NOV 21 1922, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1922, to Nov 20, 1922

that I last saw him alive on Nov 19, 1922

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis - (Left side)
Chronic Valvular Heart-
Disease (Mitral).

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arthritis Deformans

(duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Wm. Cappage, M. D.

, 19 (Address) 2303 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Nov 23 1922

20 UNDERTAKER John Decerich

ADDRESS 2007 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69378

CERTIFICATE OF DEATH.

101-001

D69378

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1786 Battery Ave ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Hogan

(Residence in Baltimore: No. 1786 Battery Ave St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) ..... (Day) 1838 (Year)

7-AGE, 84 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Day
(b) General nature of industry, business, or establishment in which employed (or employer)..... Moving Transfer

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Wm. Hogan

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Catherine Quill

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm. Johnson

(Address 1786 Battery Ave.

15-

Filed....., 191.....

Robert F. Harrison, Registrar.

NOV 21 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 19 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 17 1922, to Nov 19 1922, that I saw h[illegible] alive on Nov 19 1922, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) .....yrs. .....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Hubert Tekmayer, M. D.

Nov 21, 1922 (Address) 1216 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, Nov 22, 1922

20-UNDERTAKER Margaret L. Hynes

ADDRESS 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69379

CERTIFICATE OF DEATH.

11-002 D69379

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 N. Carey ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Maria Pritchett

(a) RESIDENCE. No. Bishop's Head—Md. ST., WARD. Bishops Head-Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Moses Edward Pritchett

6 DATE OF BIRTH (month, day, and year) Jan 28 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work home-wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Dorchester Co., Md.

PARENTS

10 NAME OF FATHER Valentine Cannon.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester County, Md.

12 MAIDEN NAME OF MOTHER Amelia Rivark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester County, Md.

14 Informant Beulah Whilhom. (Address) 417 N. Carey St.

15 Filed NOV 21 1922, 19 Robert F. Carlson, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 21 - 1922

17 I HEREBY CERTIFY, That I attended deceased from November 12 -, 1922, to November 21, 1922; that I last saw h[illegible] alive on November 20, 1922, and that death occurred, on the date stated above, at 2: a. m.

The CAUSE OF DEATH* was as follows:

Influenzal Encephalitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chester Riland, M. D.

11-24, 1922 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown, Md

DATE OF BURIAL: Nov 23 19

(Undertaker) H. N. Thompson Funeral Co

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69380

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69380

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 430 y Mannor ave ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Rebecca Gaylard

(a) RESIDENCE No. 430 y Mannor ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): about 1845

7 AGE — Years: 77 — Months: 7 — Days: 6 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Jno Gaylard

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Sarah Duvall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs McClintock (Address) 430 y Mannor

15 Filed Nov 21 1922 Robert P. Harrison, Daniel Ferrit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 21 1922

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1922, to Nov. 21, 1922, that I last saw her alive on Nov. 21, 1922, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis - Myocarditis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gustav H Wolpeneck M. D.

Nov 21, 1922 (Address) 1120 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 23 1922

20 UNDERTAKER: M. J. Sullivan Son — ADDRESS: Norbeck

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69381

D69381

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1532 N. Caroline ST.: 9 WARD)

2-FULL NAME Mary J. Koehler

(a) RESIDENCE. NO. 1532 N. Caroline ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September-11-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): 090

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER George L. Koehler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Mary Reuter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Agnes Koehler
(Address) 1532 N. Carroll St.

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 19 1922

17 I HEREBY CERTIFY, That I attended deceased from November-6, 1922, to November-19, 1922, that I last saw her alive on November-19, 1922, and that death occurred, on the date stated above, at 3 00 P. m.

The CAUSE OF DEATH* was as follows:
Cardiac Failure Toxemia-Thrombosis and Gangrene Right leg.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) William P. Schwartz, M. D.

11/21, 1922 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Nov. 22 1922

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Hartford Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

12 1922

D69382

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69382

CERTIFICATE OF DEATH.

100-002

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2139 W. Fayette St. St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ruckle

(Residence in Baltimore: No. 2139 W. Fayette St. St. 4 yrs., 4 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. July 10th 1918
(Month) (Day) (Year)

7-AGE. 4 yrs. 4 mos. 10 ds. If LESS than 1 day ....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Edgar P. Ruckle

11-BIRTHPLACE OF FATHER. (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Frances Mulcarey

13-BIRTHPLACE OF MOTHER. (State or Country). Washington, D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar P. Ruckle

(Address) 2139 W. Fayette St.

15-

Filed NOV 21 1922 192.....

Robert P. Harris
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 20th 192 2
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said decessed came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Coup. Bronchitis
Chronic
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Geo Claudius Rhodes M. D.
(Coroner.)

Nov. 21 192 2 (Address) 1135 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	Nov 23 192 2
20-UNDERTAKER. Joseph B. Cook	ADDRESS 1003 N. Balto St

Every item of information should be carefully supplied. Exact statement of OCCUPATION must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D69383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X57

D69383

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.; 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winifred Bossom -

(a) RESIDENCE. No. University Hosp St., Ward. Hampstead, Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Sing le

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1909 -

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
13 -	8 -		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hampstead
(State or country) Maryland

PARENTS

10 NAME OF FATHER John M. Bossom

11 BIRTHPLACE OF FATHER (city or town) Hampstead
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie M Royston

13 BIRTHPLACE OF MOTHER (city or town) Hampstead
(State or country) Maryland

14 Informant John M. Bossom
(Address) Hampstead Md -

15 Filed NOV 22 1922 [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 22 1922

17 I HEREBY CERTIFY, That I attended deceased from November 21, 1922, to November 22, 1922, that I last saw h alive on November 22, 1922, and that death occurred, on the date stated above, at 2.50 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis -

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no -

What test confirmed diagnosis? Clinical & Lab. findings

(Signed) Anthony V Buchness, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grace Church, Balto Co	Nov 25 1922

20 UNDERTAKER W. J. Pickus Sons ADDRESS Walbrook Md

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69384

CERTIFICATE OF DEATH.

117 D69384

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 936 Warner (St.) 21 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Egans

(a) RESIDENCE NO. 936 Warner ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 11-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	45	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Chemical Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Egans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virg.

14 Informant Ada Jackson

(Address) 657 Wilkes

15 Filed NOV 22 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1922 to Nov 18, 1922,

that I last saw him alive on Nov 17, 1922,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acute Peritonitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H S M Card M. D.

11/20, 1922 (Address) 2007 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Nov 22, 22

20 UNDERTAKER John N. Toadvine — ADDRESS 1412 N Hill Av

N. B. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

D69385

REGISTERED NO. D69385

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH a

CITY OF BALTIMORE: (No. Aged men & women's Home WARD) col.

2-FULL NAME Laura Coopsew

(a) RESIDENCE. NO. 1622 Druid Hill Ave WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Owens (Address) 1622 Druid Hill Ave

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk.

NOV 22 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 20 / 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1922, to Nov. 20, 1922,

that I last saw h alive on Nov. 20, 1922

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

(Cardiac) Mitral Insufficiency

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Pheallon, M. D.

11/21, 1922 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 22 1922
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Orchard St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69386

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69386

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers of America Hospital, ST.) 18 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Romie Seebo

(a) RESIDENCE. NO. 919 Hollins ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30 - 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hustler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Romie Seebo

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Jennie Seebo

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Mrs Chas Cochran
(Address) Old Frederick Road

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1922, to Nov 20, 1922, that I last saw h[im] alive on Nov 20, 1922, and that death occurred, on the date stated above, at 7.05 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Progressive heart exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pneumococci in sputum

(Signed) Albert J. Conrey, M. D.

, 19 (Address) Vol. of America Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	11-22 1922
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Catlin Hollins

N. B.—WHITE PAPER, WITH CARBON ATTACHED, FURNISHED FREE. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 22 1922

Burial Permit Clerk

D69387

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69387

CERTIFICATE OF DEATH.

188-003

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Chesapeake Ave. & 1st. St. Brooklyn. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Kirel Woschuk.

(Residence in Baltimore: No. 123 S. Spring St. St.; 10 yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Fictitious figures cannot be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male.	White.	Single

6-DATE OF BIRTH. October 1ſth. 1892. 1..... (Month) (Day) (Year)

7-AGE. 30 yrs. 1 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Russia.

PARENTS.

10-NAME OF FATHER. Roman Woschuk.

11-BIRTHPLACE OF FATHER, (State or Country). Russia.

12-MAIDEN NAME OF MOTHER. Ohfey ---------

13-BIRTHPLACE OF MOTHER, (State or Country). Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicholas Kluka.

(Address) 113 S. Rond St.

15- Filed NOV 22 1922 19.. ROBERT R. KRAUTER Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 18th. 1922. 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intra cranial Hemorrhage due to a fracture of the skull.
Automobile accident.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto K. Reinhardt M. D. (Coroner.)

Nov. 21. 192.. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Nov. 24th. 1922
20-UNDERTAKER.	**ADDRESS**
John Grebliauckas	425 S Paca St.

L. G.

D69388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69388

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Bayanas

(Residence in Baltimore: No. 110 N. Bren St.; yrs., 25 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 34 yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sailor
(b) General nature of industry, business, or establishment in which employed (or employer): Sailor

9-BIRTHPLACE, (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER, Jos. Bayanas

11-BIRTHPLACE OF FATHER (State or Country), L —

12-MAIDEN NAME OF MOTHER Annie Blzteo

13-BIRTHPLACE OF MOTHER (State or Country), L —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno A. Bayanas

(Address) 110 N Bren

15- Filed NOV 22 1922, 101 ROBERT R. KRAUTER, Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 19, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbuncle
Hyp. Stat. Pneumonia
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. S. Kelly M. D.
(Coroner.)
Nov 21, 1922 (Address) 1023 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Nov. 24th 1922

20-UNDERTAKER John Grebliauckas & Co — ADDRESS 425 S Paca St.
F.D.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69389

CERTIFICATE OF DEATH.

161-001

D69389

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 E 23 dct ST., 12 WARD)

2-FULL NAME Baby Shield

(a) RESIDENCE NO. 325 E 23 dct ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 11/20/22

7 AGE: Years ..... Months ..... Days ..... If LESS than 1 day, ½ hrs. or 1 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ud

(b) General nature of industry, business, or establishment in which employed (or employer): ud

(c) Name of employer: ud

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER James A Shield

11 BIRTHPLACE OF FATHER (city or town) Va (State or country) Virginia

12 MAIDEN NAME OF MOTHER Marie Morgan

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country) Virginia

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 22 1922 19.... ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/20th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1922, to Nov 20, 1922, that I last saw h alive on Nov 20, 1922, and that death occurred, on the date stated above, at 7.45 p m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ud

Did an operation precede death? ud Date of ud

Was there an autopsy? ud

What test confirmed diagnosis? physical exam

(Signed) Ad Hall, M. D.

, 19 (Address) 426 E 23 dct

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL .....

20 UNDERTAKER ..... ADDRESS .....

NOV 23 1922

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

376

19681

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69390

CERTIFICATE OF DEATH.

88

D69390

1-PLACE OF DEATH Church Home & Inf.

CITY OF BALTIMORE: (No.) Broadway & Fair (St.) (WARD) 76

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss. Helen Meyer

(a) RESIDENCE NO. 715 S. 3rd St. Highland Town WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 4 - 1900

7 AGE — Years: 22 — Months: 9 — Days: 18 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer): C.O. Dept. 809

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Joseph C. Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Margaret Nolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City.

14 Informant: Joseph C. Meyer

(Address): 715 S 3rd St.

15 Filed NOV 22 1922 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20, 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1922, to Nov 20, 1922,

that I last saw her alive on Nov. 20, 1922,

and that death occurred, on the date stated above, at 2.10 p m.

The CAUSE OF DEATH* was as follows:

Septicemia.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Endocarditis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical Methods

(Signed) K.B. Rice, M. D.

19 (Address) Church Home.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: Nov 24 1922

20 UNDERTAKER: Lilly and Zile

ADDRESS: 403 Lwood

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D69391 — CERTIFICATE OF DEATH. — 44 — D69391

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1150 Cleveland ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Erbe ELIZABETH. ERBE.

(a) RESIDENCE NO. 1150 Cleveland St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Erbe Sr

6 DATE OF BIRTH (month, day, and year) Apr 8/1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	[illegible]	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Peter Engert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Maria Klahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs H. Erbe (Address) 1150 Cleveland St

15 Filed NOV 23 1922 ROBERT P. KRAUTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20/1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1922, to Nov 20/22, that I last saw her alive on Nov 20, 1922, and that death occurred, on the date stated above, at 2.50 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

Complications (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of —

Was there an autopsy? no

What test confirmed diagnosis? Appearance

(Signed) John B Holland, M. D.

Nov 21/22 (Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 23rd 1922
20 UNDERTAKER	ADDRESS
Geo Lindenbach & Sons	647 W Baltimore

NOTE—Physicians and Midwives are required by law to report every case of death coming under their observation. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D69392

D69392

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1150 Cleveland St ST., 21 WARD)

2-FULL NAME Henry Erbe HENRY. ERBE

(a) RESIDENCE NO. 1150 Cleveland St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Erbe

6 DATE OF BIRTH (month, day, and year) Oct 1 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Erbe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Wilke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs H. Erbe
(Address) 1150 Cleveland St

15 Filed ..... 19..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20/22

17 I HEREBY CERTIFY, That I attended deceased from Nov 16/22, 19..... to Nov 20/22, 19.....

that I last saw him alive on Nov 20/22, 19.....

and that death occurred, on the date stated above, at 8:50 AM

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 7 yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Heart Disease

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Henry Bloch, M. D.

Nov 21/22 (Address) 1203 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 23d 19 22
20 UNDERTAKER Geo Leimbach & Son	ADDRESS 647 W Baltimore

N. B.—WRITE PLAINLY, with indelible pencil. All the questions must be answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69393 HEALTH DEPARTMENT—CITY OF BALTIMORE D69393

CERTIFICATE OF DEATH. 179 Registered No. C.....

1-PLACE OF DEATH Franklin Sq Hospital

City of BALTIMORE: (No. 6 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Augustine Holley

(Residence in Baltimore: No. 1347 Goodyear St. St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH. Nov (Month) 13 (Day) 1915 (Year)

7-AGE. 7 yrs. mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER. Wm. H. Holley

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Ethel Grice

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Holley

(Address) 1347 Goodyear St

15-

Filed NOV 22 1922 192.....

Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 20 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

AC. Burns.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) 1 yrs. mos. ds.

(Signed) Geo Edmund Blake M. D.

(Coroner.)

Nov 21 1922 (Address) 143 E Eager

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St. Peters Cemetery	Nov 27 1922

20-UNDERTAKER. Jas. H. Dent

ADDRESS 203 Freedman

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Accidental Burns while playing with matches.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"), *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 2^{0} *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia.*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D69394

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155 D69394

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Herman Wachovsky

(a) RESIDENCE. No. 1718 E. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 11-1919

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Wachovsky

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Yaffe

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant
(Address) Hosp

15 Filed ... 19 ... Registrar

ROBERT P. KRAUTER, Burial Permit Clerk.

NOV 22 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1922, to Nov 21, 1922

that I last saw him alive on Nov 21, 1922,

and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

General Toxemia & pulmonary edema.

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) acute osteomyelitis of left tibia

staphylococcus septicemia (duration) ... yrs. ... mos. 9 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 9/18/22

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Adolf Lorenz Rheimer, M. D.

11/21, 19 22 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Workmen circle Cem	9/22 1922

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Baltimore

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69395

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69395

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 S. Bond ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Kimel

(a) RESIDENCE NO. 225 South Bond St., ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
Mary Kimel

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant J. Levin
(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1922, to Nov. 21, 1922.

that I last saw him alive on Nov. 21, 1922.

and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Bright's disease, Chronic

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema, Myocarditis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore H. Morrison, M. D.

, 19 (Address) 1213 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 11/22 1922

20 UNDERTAKER Jack Levin

ADDRESS 1439 E Baltimore St

NOV 22 1922 Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69396

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 D69396

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Robt Garrett Hosp for Children

CITY OF BALTIMORE: (No. 27 N. Carey ST. 25 WARD)

2-FULL NAME Amy Petersen

(a) RESIDENCE No. 210 Patapsco ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 7, 1922

7 AGE: Years | Months: 3 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Richard L Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wisconson

12 MAIDEN NAME OF MOTHER: Mae Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Gw Knell

(Address): 917 Columbia Ave

15 Filed NOV 22 1922, 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 17th, 1922, to Nov 21st, 1922,

that I last saw her alive on Nov 20th, 1922,

and that death occurred, on the date stated above, at 6 50 A m.

The CAUSE OF DEATH* was as follows:

(Malnutrition) Intestinal Indigestion. 3

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) L. W. Cliff, M. D.

11/21, 1922 (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Nov 23 1922

20 UNDERTAKER: Knell & Son — ADDRESS: 1729 Bulto St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69397

CERTIFICATE OF DEATH.

X160 D69397

1-PLACE OF DEATH St Vincents Infant Asy

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1401 - Division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Taylor

(a) RESIDENCE NO. 1401 Division St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 28" 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) " " (State or country) Carolina

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) " " (State or country) Carolina

14 Informant Sister Vincent Infant Asy
(Address) 1401 Division St

15 Filed ROBERT A. KNABE, 19 .....
Burial Permit Clerk. NOV 22 1922
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18" 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1922 to Nov. 18, 1922 that I last saw him alive on Nov 18, 1922 and that death occurred, on the date stated above, at 11-30 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus
(Malnutrition)
(duration) yrs. mos ds.

CONTRIBUTORY - (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. L. Goldborough M. D.

19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudenslager Cem — DATE OF BURIAL Nov 21 22

20 UNDERTAKER Marion Harkey & Sons — ADDRESS 1823 W North Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—1-10-21—M&T—1500 Blks.

D69398

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69398

CERTIFICATE OF DEATH.

45

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2027 N Charles ST., 12 WARD)

2-FULL NAME Mrs Annie E Moore

(a) RESIDENCE NO. 2027 N Charles ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James H Moore

6 DATE OF BIRTH (month, day, and year): June 22 1856

7 AGE: Years: Was 66 | Months: 5 | Days: — | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Mr Kinnon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mr Kinnon

12 MAIDEN NAME OF MOTHER: Ruth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mr Kinnon

14 Informant: Miss Adelaide Moore

(Address): 2027 N Charles St

15 Filed NOV 22 1922, 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 21 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 20 1922, to Nov 21 1922, 19 .

that I last saw h alive on Nov 21 1922,

and that death occurred, on the date stated above, at 9-30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Ephemisitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of 1921 | 1922 2-24

Was there an autopsy? .....

What test confirmed diagnosis? Physical examination

(Signed) Wm E Selby M. D.

Nov 22 22 (Address) 800 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Snow Shoe Pa.

DATE OF BURIAL: Nov 22 1922

20 UNDERTAKER: H Maund Routson

ADDRESS: 230 N Eutaw

Spec.—1-10-21—M&T—1500 Bks.

Bonarrigo ✓

D69399

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69399

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Childs Hospt ST., 70 WARD)

2-FULL NAME Lillian May Josephine Bonarrigo

(a) RESIDENCE NO. 121 McCulloh Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 19, 22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Nunzio Bonarrigo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Catherine Schepis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Nunzio Bonarrigo (Address) 121 McCulloh Ave.

15 Filed NOV 22 1922 19 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1922, to Nov 21, 1922, that I last saw h[illegible] alive on Nov 21, 1922, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Indigestion.

(duration) 0 yrs. 2 mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Oral J. Franklin, M. D.

, 19 (Address) 100 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov 23, 1922

20 UNDERTAKER C. W. Dill — ADDRESS 3109 Frederick Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Farmer. 1405 Bay St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69400

CERTIFICATE OF DEATH.

90 D69400

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Rosemont Ave & Belair Rd ST.; 27th WARD)

2-FULL NAME Mary Elizabeth Morris

(a) RESIDENCE. No. Rosemont Ave & Belair Rd ST.; 27th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Owen Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Annette Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Jean Hanson
(Address) 1910 Callow Ave

15 Filed NOV 22 1922 19 ROBERT R. KRAUSE Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1922 to Nov 20 1922

that I last saw h alive on Nov 20 1922

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Diaphragmatic Pleurisy

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arthritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William Frazer M. D.

19 (Address) 1407 Bay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto	Nov 22 1922

20 UNDERTAKER H M Cook ADDRESS 902 E Fayette

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69401

CERTIFICATE OF DEATH.

31

D69401
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 642 W Saratoga ST., 4 WARD)

2-FULL NAME John W. Butler

(a) RESIDENCE NO. 642 W. Saratoga ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E Butler

6 DATE OF BIRTH (month, day, and year) Oct 27 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44		26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of Industry, business, or establishment in which employed (or employer) Saloon 070
(c) Name of employer Dallo Md

9 BIRTHPLACE (city or town) (State or country) Dallo Md

PARENTS
10 NAME OF FATHER John L Butler
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Alena Grimmell
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie E Butler
(Address) 642 W Saratoga

15 Filed NOV 22 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1922, to Nov 20, 1922, that I last saw him alive on Nov 20, 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lung

(duration) 2 yrs. 1 mos 1 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Mic. Exam.

(Signed) R B Tennyson, M. D.

, 19 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 11/23 1922

20 UNDERTAKER Daniel J Hensley

ADDRESS 578 W Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D69402 HEALTH DEPARTMENT—CITY OF BALTIMORE

D69402

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary 16

REGISTERED NO. 60-002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Mr Charles O Schultz

(a) RESIDENCE NO. Hampstead, Maryland ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 27				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Andrew Schultz

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Florence Miller

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant C. V. Tipton Jr
(Address) Hampstead

15 Filed ..... 19 .....

Registrar

NOV 22 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 18, 1922 to Nov 21, 1922,

that I last saw him alive on Nov 21, 1922

and that death occurred, on the date stated above, at 10 05 P m.

The CAUSE OF DEATH* was as follows:

Cystic adenoma of thyroid

(duration) about 1 yr

CONTRIBUTORY (Secondary) Post operative Septicemia

(duration) — yrs. 1 mo. — ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? Yes Date of Oct 20 '22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Keith & Rice, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampstead, Md — DATE OF BURIAL Nov 24 1922

20 UNDERTAKER Wm J Lickenbrock — ADDRESS N & Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69403

CERTIFICATE OF DEATH.

90 D69403

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 Madison Ave. ST. 14 WARD)

2-FULL NAME Mary L. Lenhart

(a) RESIDENCE NO. 1809 Madison Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen Lenhart

6 DATE OF BIRTH (month, day, and year) May 13 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	62	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Littlestown Pa. (State or country)

PARENTS

10 NAME OF FATHER Samuel Shildt

11 BIRTHPLACE OF FATHER (city or town) Penna. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Charles Poke

(Address) 1809 Madison Ave.

15 Filed ....., 19 .....

ROBERT R. KRAUTER, Registrar

NOV 22 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to Nov 20, 1922, that I last saw her alive on Nov 20, 1922 and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Aortic & Mitral Insufficiency

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Chyle Ethiosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles J Bloke M. D.

Nov 21 1922 (Address) 702 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL loudon Park Cemetery

DATE OF BURIAL 11/23 1922

20 UNDERTAKER William M. Gawthrop

ADDRESS 2839 Rayner

Spec.—1-10-21—M&T—1500 lbs.

D69404

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69404

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2921 O'Donnell ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie C. Cannon.

(a) RESIDENCE NO. 2921 O'Donnell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. C. Cannon

6 DATE OF BIRTH (month, day, and year) July 20 1896.

7 AGE Years 26. Months + Days 1

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Conrad Wolf.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Hezius

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mr. Geo. C. Cannon

(Address) 2921 O'Donnell St

15 Filed , 19 Registrar

Robert F. Harrison,

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 20, 1922, to Nov 21, 1922,

that I last saw her alive on Nov 21, 1922,

and that death occurred, on the date stated above, at 10.55 A m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acut myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Test + Observation

(Signed) H B Litton M. D.

Nov 22, 1922 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft. Lawn

DATE OF BURIAL Nov 24 1922

20 UNDERTAKER K. Freeman

ADDRESS 824 Brady

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 27 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69405

CERTIFICATE OF DEATH.

74-001

D69405

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Michael Zominski

(a) RESIDENCE. NO. Preston Valley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Wid Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Madaliński.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Near Germany

PARENTS

10 NAME OF FATHER Martin Zominski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Anna Taranska

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Florence, (Address) Preston Valley St.

15 Filed Nov 25 1922 Richard P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1922

17 I HEREBY CERTIFY, That I attended deceased from No record, 19, to, 19,

that I last saw h[im] alive on Nov 19, 1922,

and that death occurred, on the date stated above, at 4. a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

3 mos (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Nov 22, 19 (Signed) F. A. Warner, M. D. (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Nov 23 1922

20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmt Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69406 HEALTH DEPARTMENT—CITY OF BALTIMORE D69406

CERTIFICATE OF DEATH.

73

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2203 Aiken ST., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry G. Glass

(a) RESIDENCE NO. 2203 Aiken ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Glass

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 67 Months 5 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): P. O. Clerk 09

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Jas A. Glass

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Sarah V Galt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Mary E. Glass 2203 Aiken St

15 Filed NOV 22 1922, 19 Robert F. Harrigan, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10th, 1918, to Nov. 20th, 1922, that I last saw him alive on Nov. 20th, 1922, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Insanemia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Paralysis agitans

(duration) 12 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No (Physical findings

What test confirmed diagnosis?

(Signed) Elijah J Rumsey, M. D.

11/20, 1922 (Address) 156 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: 11/23 1922

20 UNDERTAKER: Chas P. Evans & Son

ADDRESS: 118 W. Mt Royal ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69407

CERTIFICATE OF DEATH.

57

D69407

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2039 Harlem ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas J Rhodes

(Residence in Baltimore: No. 2039 Harlem ave St.; 4 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, unknown, 1 (Month) (Day) (Year)

7-AGE, About 57 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Minister
(b) General nature of industry, business, or establishment in which employed (or employer) Gospel 1625

9-BIRTHPLACE, (State or Country) England

PARENTS.

10-NAME OF FATHER, John Rhodes

11-BIRTHPLACE OF FATHER (State or Country) England

12-MAIDEN NAME OF MOTHER Jane Jacomb

13-BIRTHPLACE OF MOTHER (State or Country) England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Rhodes

(Address) 2039 Harlem Ave

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

NOV 22 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 21 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 9th 1922, to Nov 21st 1922, that I saw h[illegible] alive on Nov 21st 1922, and that death occurred, on the date stated above, at 2-20 P.m.

The CAUSE OF DEATH* was as follows:

a.....

Cerebral Hemorrhage

.....

..... (Duration) .....yrs.....mos. 14 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

..... (Duration) 4 yrs.....mos.....ds.

(Signed) Karl H. Mennes M. D.

Nov 21st, 1922. (Address) 1619 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Same

19-PLACE OF ~~BURIAL~~ OR REMOVAL, Western

DATE OF BURIAL, Nov 24, 1922

20-UNDERTAKER Wm Cook

ADDRESS 502 E North

I. D. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

D69408

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69408

CERTIFICATE OF DEATH.

REGISTERED No. C 168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mt Hope Retreat St. 3rd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Frazel

(Residence in Baltimore: No. 1617 Cuba St (Don't Know.)

St.; yrs. 35 mos. 10 ds. 29)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Dec (Month) 24 (Day), 1886 (Year)

7-AGE, 35 yrs. 10 mos. 29 ds. If LESS than 1 day, ...hrs. or....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tally Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): Tallying (?)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Frank Frazel

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Schroder

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rec'd of Mt Hope Retreat

(Address) Mt Hope Retreat

15-

Robert P. Harrison,

Filed....., 191.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 22nd (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Strangulation
(Cotton or Cambric Strap)
(Duration) ..... yrs. 2 mos. ?? ds.

CONTRIBUTORY (Secondary) Melancholia
(Duration) ..... yrs. 4 mos. 14 ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Nov. 22, 1922 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 4 mos. 14 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Baltimore Md

Former or usual residence 1617 Cuba St.

19-PLACE OF BURIAL OR REMOVAL, Holy Cross A. A. Co — DATE OF BURIAL, Nov. 25 1922

20-UNDERTAKER Wm Cook — ADDRESS 2502 E North

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 69409

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 69409

CERTIFICATE OF DEATH.

179

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 29 Exeter St St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Frederick E Fisher

(Residence in Baltimore: No. 29 Exeter St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Unknown (Month) (Day) 1866 (Year)

7-AGE: 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Locksmith

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER, Unknown.

13-BIRTHPLACE OF MOTHER, (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Deems

(Address) 123 Washington Blvd

15-

Filed NOV 23 1922 192

ROBERT R. KRAUTER, Burial Permit Clerk (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 21st (Month) (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns 1st and 2nd degree

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

123 1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Cnuses, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Nov 23rd 1922

20-UNDERTAKER, Chas J Cowan — ADDRESS, 908 Hollins St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69410

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 919 Eutaw St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl Davis

(Residence in Baltimore: No. 919 Eutaw St. St.; yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female / male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): single

6-DATE OF BIRTH: May 9 1921
(Month) (Day) (Year)

7-AGE: 1 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: James Davis

11-BIRTHPLACE OF FATHER, (State or Country): N. C.

12-MAIDEN NAME OF MOTHER: Bessie Turner

13-BIRTHPLACE OF MOTHER, (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Davis

(Address) 919 Eutaw St.

15- Filed NOV 23 1922 192.... ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 22 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping cough

(Duration) yrs. mos. 1 wk ds.

CONTRIBUTORY (Secondary) Mo. history

(Duration) yrs. mos. ds.

(Signed) J. T. Kennedy, M. D.
(Coroner.)

Nov 22, 1922 (Address) 2 E. Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem DATE OF BURIAL, Nov 23 1922

20-UNDERTAKER, Samuel Kennedy ADDRESS W Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69411 — CERTIFICATE OF DEATH. — 38 S. D69411

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Alvin Scott.

(a) RESIDENCE NO. 936 McDowell ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie Scott

6 DATE OF BIRTH (month, day, and year): 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenedre

(b) General nature of industry, business, or establishment in which employed (or employer): 074

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant: Bay View Hospital (Address) Balto Md

15 Filed NOV 23 1922, 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1922 to Nov. 18, 1922

that I last saw him alive on Nov. 17, 1922

and that death occurred, on the date stated above, at 2.50 a.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Cystitis (Suspected)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes What test confirmed diagnosis? Clinical & Autopsy

(Signed) H. Goldsmith Thomas M. D.

11/18/ 19 22 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: NOV 24 1922, 19

20 UNDERTAKER: Commissioner Health. — ADDRESS

Per. W. S. Wood

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

577

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 ✓ D69412

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1835 Bolton St. ST. 14 WARD)

2-FULL NAME. Jessie Eppleye Wilkinson

(a) RESIDENCE. No. 1835 Bolton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas H. Wilkinson

6 DATE OF BIRTH (month, day, and year) Nov 24 th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James M. Eppleye

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Mary J Hyde

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Thomas H Wilkinson
(Address) 96 Mosher St

15 Filed NOV 23 1922 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 , 1922 , to Nov 21 , 1922 ;
that I last saw h alive on Nov 21 , 1922 ;
and that death occurred, on the date stated above, at 3.A.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum.
Metastasis. Liver + bones.
(Ribs + Ribs)

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis? none

(Signed) J.F. Thomas , M. D.

11/22 1922 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	Nov 24 19
20 UNDERTAKER	ADDRESS
E. LeRoy Stiffler	125 E. North Ave

Spec.—1-10-21—M&T—1500 Bks.

D69413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

002
159-D69413

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2048 E. Hoffman ST., 8 WARD)

2-FULL NAME Frances A. Kube

(a) RESIDENCE NO. 2048 E. Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Oct. 13 1922

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Louis M. Kube

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Frances M. Kuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Wm. L. M. Kube

(Address) 2048 E. Hoffman St.

15 Filed NOV 23 1922 19 Registrar

ROBERT R. KRAUSER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1922, to Nov 22, 1922,

that I last saw h alive on 19,

and that death occurred, on the date stated above, at 12 05 P m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Insufficiency

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John H Avery, M. D.

(Address) 1603 Bressler

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Cathedral Cemetery — DATE OF BURIAL: Nov 24 1922

20 UNDERTAKER: Henry Horck Son — ADDRESS: 1301 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69414 100-001 D69414

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1838 Ashland ave ST.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mae Silberstack

(Residence in Baltimore: No. 1838 Ashland ave St.; 3 yrs. 7 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, ... (Month) Feb (Day) 19, (Year) 1919

7-AGE, 3 yrs. 7 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER, Herbert Silberstack

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Ruby Moore

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert Silberstack

(Address) 1838 Ashland ave

15-

Filed....., 191.....

Registrar.

NOV 23 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 21 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 17 1922 to Nov 21 1922 that I saw h[illegible] alive on Nov 21 1922, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as followa:

Broncho Pneumonia

(over)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration)....yrs....mos....ds.

(Signed) [signature] M. D.

11-23-22, 1922 (Address) 1838 Ashland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore County — DATE OF BURIAL, Nov 23, 1922

20-UNDERTAKER Frank Creighton — ADDRESS 1900 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 Mk'T. 1500 Bks.

D69415

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69415

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4th Ave. and 5th St. ST., Fairfield WARD) 25

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William McNeely

(a) RESIDENCE NO. 4th Ave. and 5th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. 20 hours. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Nov. 17 '22.

7 AGE: Years | Months | Days: 1 20 hrs. | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Fairfield, Baltimore Md.

PARENTS

10 NAME OF FATHER: Eli McNeely

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Maggie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Eli McNeely

(Address) 4th Ave. and 5th St.

15 Filed NOV 23 1922, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1922, to Nov. 19, 1922, that I last saw him alive on Nov. 18, 1922, and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Congenital debility

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Maternal hydramnios, due probably to syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. B. Davis, M. D.

11/19, 1922 (Address) 211 Church St., Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: Nov 22 1922

20 UNDERTAKER

ADDRESS

NOV 23 1922 ROBERT R. KRAUTER, Commissioner of Health. Per. Wm. S. WOSSELL

Sec. 8. WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69416

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D69416

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Dorothy Zinkand

(Residence in Baltimore: No. Jones Town Md St.; yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. May (Month) 4 (Day) 1922 (Year)

7-AGE.	If LESS than 1 day,
....yrs. 6 mos. 18 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. John Zinkand

11-BIRTHPLACE OF FATHER, (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER. Florence Stickling

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Zinkand

(Address) Jones Town Md

15-

Filed NOV 23 1922 192.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 22 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Interstitial Pneumonitis

Intoxication (Fatal) Lungs

Duration (Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Autopsy at Hospital

(Duration)....yrs....mos....ds.

(Signed) J. S. Culler M. D.
(Coroner)

Nov 22 192.. (Address) 506 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Itecent Itesidents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cem	Nov 23 1922

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 W. Baltimore St

Spec.—1-10-21 M&T 1500 Blks.

D69417

D69417 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2443 Maryland Ave. ST., 17 WARD)

2-FULL NAME Annie E. Gray

(a) **RESIDENCE NO.** 2443 Maryland Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert C. Gray

6 DATE OF BIRTH (month, day, and year) July 2" 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Accomac Co. (State or country) Va.

PARENTS

10 NAME OF FATHER James Selby

11 BIRTHPLACE OF FATHER (city or town) Accomac Co. (State or country) Va.

12 MAIDEN NAME OF MOTHER Godwin

13 BIRTHPLACE OF MOTHER (city or town) Accomac Co (State or country) Va.

14 Informant Minnie V. Gray

(Address) 2443 Maryland Ave.

15 Filed NOV 23 1922 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22" 19 22

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15 , 19 22 , to Nov 22 , 19 22 ,

that I last saw h[illegible] alive on Nov. 22 , 19 22 ,

and that death occurred, on the date stated above, at 12[15] P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

11/23 19 22 (Address) 1733 Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov. 25" 1922
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St

I. B. Write plainly, preferably with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69418

CERTIFICATE OF DEATH.

D69418

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 W. Fayette St. ST., 18 WARD)

2-FULL NAME Ethel Louisa Oetter

(a) RESIDENCE NO. 921 W. Fayette St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 28" 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER August Oetter

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mabel Ritterbaugh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant Mrs. August Oetter

(Address) 921 W. Fayette St.

15 Filed NOV 23 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22" 19 22

17 I HEREBY CERTIFY, That I attended deceased from Nov 17 , 1922 , to Nov 22 , 1922 , that I last saw her alive, on Nov 21 , 1922 , and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) Yrs. About mos 10 ds.

CONTRIBUTORY (Secondary) None

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? ✓ What test confirmed diagnosis? Physical Examination

(Signed) [illegible], M. D.

Nov 21 " 22 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov 24" 1922

20 UNDERTAKER Joseph L. B. Cook — ADDRESS 1003 N. Bal[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69419

CERTIFICATE OF DEATH.

122-002 D69419

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1300 Harford Ave. ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget A. Kavanaugh

(a) RESIDENCE. No. 1300 Harford Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
45				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Matthew Kavanaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ann Colbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Joseph Carroll (Address) 1300 Harford Ave

15 Filed NOV 23 1922 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov., 22nd. 1922.

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1922, to Nov 22, 1922, that I last saw her alive on Nov 21, 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver over

(duration) about 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Sudden coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert E. Evans, M. D.

Nov 1922 Address 1916 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Nov 24 19 22

20 UNDERTAKER Chas J. Evans & Son ADDRESS 118 N. Mt Royal ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-alcoholic

Spec.—1-10-21—M&T—1500 Bks.

D69420

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69420

CERTIFICATE OF DEATH.

4.6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 24 Grinden Ave ST. Walbrook WARD

2-FULL NAME Pauline E. Parish

(a) RESIDENCE NO. 24 Grinden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm F Parrish

6 DATE OF BIRTH (month, day, and year) Oct 2 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) New Castle

PARENTS

10 NAME OF FATHER John Boyd Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Emma Mearns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm F Parrish

(Address) Lansdowne

15 Filed NOV 23 1922 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1922.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st 1921, to Nov 22nd 1922,

that I last saw her alive on Nov 22nd 1922,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteris

(duration) 3 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Gonoch Ave

Did an operation precede death? No Date of Impossible

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) Chas W Stern, M. D.

19 (Address) 4062 Sth

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Nov 25 19

20 UNDERTAKER Wm Cook 502 E

ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69421 D69421

CERTIFICATE OF DEATH.

99-002 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 Anthony ST.: 10 WARD)

2-FULL NAME Albert Behling

(a) RESIDENCE. NO. 1405 Anthony ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dorothy Behling

6 DATE OF BIRTH (month, day, and year): March 24-1852

7 AGE — Years: 72 Months: 7 Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Dorothy Behling
(Address): 1405 Anthony

15 Filed . 19 . Robert P. Harrison, Registrar

NOV 23 1922

1501 E. Eager Belleve

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 18th 22, to Nov 21st 22, that I last saw h[illegible] alive on Nov 21st 22, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Pancreatic

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Cystitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

Nov 22, 19 (Address) 504 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz

DATE OF BURIAL: Nov 24 1922

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69422

D69422

CERTIFICATE OF DEATH.

X 86-001

1-PLACE OF DEATH Robt Garrett Hosp for Children

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 27 N Carey ST., 18 WARD)

2-FULL NAME Charles Smith

(a) RESIDENCE NO. 410 E F St Sparrows Point WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 28 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Sparrow Pt
(State or country) Md

PARENTS

10 NAME OF FATHER Chas Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Indiana

12 MAIDEN NAME OF MOTHER Grace E Simpson

13 BIRTHPLACE OF MOTHER (city or town) Orange
(State or country) Va

14 Informant Chas Smith
(Address) Sparrows Point Md

15 Filed ..... 19 ..... Registrar

11 23 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1922

17 I HEREBY CERTIFY, That I attended deceased from October 25 1922, to Nov 23 1922.

that I last saw him alive on Nov 22 1922,

and that death occurred, on the date stated above, at 2 35 A m.

The CAUSE OF DEATH* was as follows:

Premature

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Double Cleft Palate

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. W. K. Clift M. D.

11/23, 1922 (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Nov 23 1922

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH CARBON PAPER. All the questions should be answered EXACTLY. PHYSICIANS should supply information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

(James Ferguson) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69423

D69423

CERTIFICATE OF DEATH. X 49

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jas Ferguson

(a) RESIDENCE NO. 318-11th St N.W. Washington WARD D C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 22-1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	43	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gov Employee

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robt. Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed NOV 23 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1921, to Nov 21, 1922

that I last saw him alive on Nov 21, 1922,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Prostate & metastases

2 -

(duration) 2-3 yrs. mos ds.

CONTRIBUTORY (Secondary) Cachexia.

(duration) yrs. 5-6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? C

(Signed) D Brannan, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL La Vista Md

DATE OF BURIAL Dec 2 1922

20 UNDERTAKER N. S. Marshall ADDRESS 3539 Falls Road

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT IS PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69424

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69424

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Robt Garrett Hosp for Children REGISTERED NO.

CITY OF BALTIMORE: (No. 27 N Carey ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis L Dollinger

(a) RESIDENCE NO. 1815 Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 6-1922

7 AGE: Years — Months 6 — Days 17 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Louis L Dollinger

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Grace M Linton

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Louis C Dollinger

(Address) 1815 N Montford Ave

15 Filed . 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1922, to Nov 22, 1922, that I last saw him alive on Nov 22, 1922, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis (Periostitis)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Double Otitis Media & Mastoiditis (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical & Xray & Lg

(Signed) J. W. V. Cliff M. D.

11/23, 1922 (Address) 27 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov 24th 1922

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE SHOULD BE FILLED OUT IN THE PRESENCE OF THE INFORMANT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

NOV 23 1922

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69425

CERTIFICATE OF DEATH.

72

D69425

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Edmondson Ave ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony A Forasti

(Residence in Baltimore: No. 1211 Edmondson Ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 14, 1850 (Month) (Day) (Year)

7-AGE, 72 yrs. 2 mos. 8 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Artist
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Venice Italy

PARENTS.

10-NAME OF FATHER, Frederick Forasti

11-BIRTHPLACE OF FATHER (State or Country), Venice Italy

12-MAIDEN NAME OF MOTHER Elena Benedicto

13-BIRTHPLACE OF MOTHER (State or Country), Venice Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Rose Forasti

(Address)..... 1211 Edmondson Ave

15-

Filed..... Robert J. Harrison, 191.....

NOV 23 1922 Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 22, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15th 1922, to Nov 22 1922, that I saw him alive on Nov 21 1922, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

..... (Duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

..... (Duration) — yrs. — mos. 4 ds.

(Signed) Hallowell F. Glutsman M. D.

Nov 23, 1922 (Address) 1227 W Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Nov. 24 1922

20-UNDERTAKER H. C. Braungardt

ADDRESS 317 N Schroeder St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D69426

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69426

CERTIFICATE OF DEATH. X 129

REGISTERED NO.....

1-PLACE OF DEATH Baltimore City

CITY OF BALTIMORE: (No. 2120 Oak ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Winifred Murphy

(a) RESIDENCE. NO. 2120 Oak ST., WARD. Boston Mass.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs 1½ mos. ds. How long in U. S., If of foreign birth? 50 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel J. Murphy

6 DATE OF BIRTH (month, day, and year): April 20-1851

7 AGE 71 Years 7 Months 2 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Daniel McNulty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): David J. Murphy. Phila Pa

15 Filed NOV 23 1922 ROBERT R. KRAUTER, Registrar

Via P R R. Co. David J. Murphy.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 22 1922

17 I HEREBY CERTIFY, That I attended deceased from November 17, 1922, to November 22, 1922.

that I last saw her alive on Nov. 22, 1922.

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) Unknown

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urine-Blood Exam

(Signed) W. H. Hagaman M. D.

, 19 (Address) 2439 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Boston Mass. DATE OF BURIAL Nov 23 1922

20 UNDERTAKER: William Lobe ADDRESS 50 E. North ave

D.69427 HEALTH DEPARTMENT—CITY OF BALTIMORE D.69427

CERTIFICATE OF DEATH. 197 Registered No. C.....

1-PLACE OF DEATH Baptist Home

City of BALTIMORE: (No. ..... St. St. Joseph's Imp. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Brown

(Residence in Baltimore: No. 1102 E. Monument St. (yrs., 4 mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Oct (Month) 11 (Day) 1876. (Year)

7-AGE. 76 yrs. 1 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Balto Bapt Home

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Henry Brown

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER, Catherine Stewart

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Brown

(Address) 812 W. Lexington St.

15- Filed Nov 28 1922 Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 20 (Day) 192.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Immediate Pistol shot wound,

Former Shot wound, Duration

Acute nephritis,

(Duration) ..... yrs. ..... mos. ..... ds.,

CONTRIBUTORY (Secondary) Autopsy by Dr. Weller

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Kolb M. D.
(Coroner)

11-23 1922 (Address) 448 E. Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hagerstown, Md.	November 25 1922.
20-UNDERTAKER.	ADDRESS
Wm. Kate R. Williams	111 W. Saratoga St.

D69428

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

D69428

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1439 Fawson Av ST.: 24 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Michael H. O'Boyle

(Residence in Baltimore: No. 1439 Fawson Av St.: 73 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: Sept. 29, 1846 (Month) (Day) (Year)

7 AGE: 76 yrs. 1 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): General

9 BIRTHPLACE (State or country): Ireland

PARENTS

10 NAME OF FATHER: Michael O'Boyle

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (State or country): Ireland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Murray.

(Address) 1330 E. Fort Ave.

15. Robert P. Harris, M.D.

Filed 11/23 1922 191 Burial Permit Issued

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: November 21, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1922, to Nov. 21 1922.

that I saw him alive on Nov. 21, 1922

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma.

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY) Chronic Interstitial Nephritis

(Duration) yrs. 2 mos. — ds.

(Signed), Thos. F. Stevens M. D.

11/22, 1922 (Address) 2878 Harford Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cathedral Cem. DATE OF BURIAL: Nov. 24, 1922

20 UNDERTAKER: Margaret E. Flynn ADDRESS: 1422 High St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69429

CERTIFICATE OF DEATH.

33 D69429

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1809 Druid Hill Av St.: 14 Ward)

2-FULL NAME James Harvey Smith

(a) RESIDENCE. No. 1809 Druid Hill Av St., 14 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 9 1904

7 AGE 17 Years 11 Months 17 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Pupil

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER James H. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Laura Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address) James H. Smith 1809 Druid Hill Av

15 Filed NOV 23 1922, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922 to Nov 21, 1922

that I last saw him alive on June 21, 1922

and that death occurred, on the date stated above, at 1.40 A m.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? Yes Date of Sept 26/22

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. B. Hyslop M. D.

Nov 23, 1922 (Address) 1413 Druid Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Md Auburn Cem — DATE OF BURIAL: 11-25 1922

20 UNDERTAKER: George T. U. Gibson — ADDRESS: 513 Lauren

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69430

CERTIFICATE OF DEATH.

44 D69430

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1823 N. Bond St ST., 8 WARD)

2-FULL NAME Henry Imwold

(a) RESIDENCE NO. 1823 N Bond St ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sadie C Imwold

6 DATE OF BIRTH (month, day, and year) 6/15 1866

7 AGE — Years: 56 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Imwold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Sadie C Imwold
(Address) 1823 N Bond St.

15 Filed NOV 24 1922 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-22-1922

17 I HEREBY CERTIFY, That I attended deceased from 10-13-, 1922, to 11-22-, 1922; that I last saw him alive on 11-21, 1922 and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Malignant tumor - at upper boundary of abdomen - stomach & liver involved - 3 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) exhaustion (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? yes -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Rays -

(Signed) S. Drumm - M. D.

11-24 1922 (Address) 1604 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 11/24 1922

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford ave

N. B.—WRITE PLAINLY, WITH INDELIBLE PENCIL. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69431 99 D69431

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Aged Home ST.: 5 WARD)

2-FULL NAME Sara Harris

(a) RESIDENCE. NO. 108 Aisquith ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) —— 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Houseworker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant L. Lewis
(Address) 1439 E Balto.

15 Filed NOV 24 1922, 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 1922, to Nov 23 1922,

that I last saw her alive on Nov 23 1922,

and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Mgr Barish, M. D.

11/24 1922 (Address) 2n Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave

DATE OF BURIAL Nov. 24 1922

20 UNDERTAKER East Lewis

ADDRESS 1431 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dolkin

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

D69432

CERTIFICATE OF DEATH.

D69432

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 15 WARD)

2-FULL NAME Miss Sylvia Dolkin

(a) RESIDENCE. No. 1021 N. Bentalou st ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept. 1918

7 AGE: Years 4 Months 2 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Maryland

PARENTS

10 NAME OF FATHER: Samuel Dolkin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md.

12 MAIDEN NAME OF MOTHER: Sarah Rosenthal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): J. Lewis 1499 E Balto

15 Filed NOV 24 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24 1922

17 I HEREBY CERTIFY, That I attended deceased from November 15 1922, to Nov. 24, 1922, that I last saw h[illegible] alive on Nov 24, 1922, and that death occurred, on the date stated above, at 2:40 A m.

The CAUSE OF DEATH* was as follows:

Circulatory failure c pul-monary edema. General Toxemia 1/2 hrs duration

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY Perforation of intestine c

(Secondary) Intussusception (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov 15/22 Nov 19/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Wilderfunkelberger, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shaw Rosedale — DATE OF BURIAL: Nov 24 1922

20 UNDERTAKER: Jacob Lewis, 1499 E Balto — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69433

REGISTERED NO. 29

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2211 Druid Hill ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Murray Roberts

(a) RESIDENCE NO. 2211 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 10 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Roberts

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Easton
(State or country) Md.

PARENTS

10 NAME OF FATHER Harry Roberts

11 BIRTHPLACE OF FATHER (city or town) Easton
(State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Denby

13 BIRTHPLACE OF MOTHER (city or town) Easton
(State or country) Md

14 Informant Eliza Johnson
(Address) 22 Druid Hill Ave

15 Filed NOV 24 1922, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1922, to Nov 23, 1922, that I last saw him alive on Nov. 23, 1922, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey, M. D.

11/23, 1922 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md.

DATE OF BURIAL Nov 26 1922

20 UNDERTAKER Joseph H. Rochester

ADDRESS 1439 Fleurmont

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69434

CERTIFICATE OF DEATH.

44 D69434

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 W. Biddle ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Levinia Robinson

(Residence in Baltimore: No. 433 W. Biddle st St.; 21 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	C	married

6-DATE OF BIRTH, March 5 (Month) (Day), 1872 (Year)

7-AGE, 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook .....
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John R. Robinson

(Address) 433 W. Biddle st

15-

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 22nd, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 26th 1922, to Nov 22nd 1922, that I saw her alive on Nov 21st 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) Chas. E. Keller M. D.

Nov 24, 1922 (Address) 222 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, Nov 25, 1922

20-UNDERTAKER Mrs. R. A. Elliott

ADDRESS 17 E. Preston

NOV 24 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69435

CERTIFICATE OF DEATH.

101-00 D69435

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2829 Remington St. 12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Johnson

(a) RESIDENCE. No. 2829 Remington St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23-1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Preston Johnson

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Harper

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Jennie Harper
(Address) 2829 Remington Ave.

15 Filed NOV 24 1922 . 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1922 to Nov 23, 1922
that I last saw h alive on Nov 23, 1922
and that death occurred, on the date stated above, at 12, m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Garland Schmidt M. D.

(Address) 1334 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Nov 24 1922
20 UNDERTAKER Mrs R. A. Elliott	ADDRESS 1727 Ashland Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69436

CERTIFICATE OF DEATH.

128 D69436

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 N. Dallas ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Anderson

(Residence in Baltimore: No. 514 N. Dallas St. St.: 43 yrs., 7 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	C	Married

6-DATE OF BIRTH, March (Month) 25 (Day), 1879 (Year)

7-AGE, 43 yrs. 7 mos. 22 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry Murray

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Nixon

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertie Green (daughter)

(Address) 514 N. Bruce St.

15- [illegible]

Filed..... 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 22 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 8 191..., to Nov 22 1922, that I saw her alive on Nov. 21 1922, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration).....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) R. [illegible] M. D.

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laural Cemetery | DATE OF BURIAL. November 25, 1922.

20-UNDERTAKER Mrs R A Elliott | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

[illegible] REGISTRAR OF VITAL STATISTICS

NOV 24 1922

BUREAU OF VITAL STATISTICS CLERK

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69437

CERTIFICATE OF DEATH.

+129 D69437

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 220 Prospect Av ST., 27 WARD)

2-FULL NAME Ellen Augusta Tickett

(a) RESIDENCE NO. 220 Prospect Av ST., 27 WARD Worcester N.Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. ? ds. How long in U. S., if of foreign birth? 76 yrs. 5 mos. 1 ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elmer E. Tikett

6 DATE OF BIRTH (month, day, and year) Jan-23-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 037

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Dover
(State or country) New Hampshire

PARENTS

10 NAME OF FATHER John Tirkey

11 BIRTHPLACE OF FATHER (city or town) Dover
(State or country) New Hampshire

12 MAIDEN NAME OF MOTHER Ellen Young

13 BIRTHPLACE OF MOTHER (city or town) Dover
(State or country) New Hampshire

14 Informant Mr. E. E. Tikett (husband)
(Address) 220 Prospect Av City

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1922, to Nov. 24, 1922, that I last saw h.. alive on Nov. 20, 1922, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Ca Cervix + Broncho-Pneumonia
Pulmonary Edema

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. Edwin Dorsi M. D.

11/27, 1922 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Worcester Otsego Co. N.Y.

DATE OF BURIAL Nov-2-1922

20 UNDERTAKER STEPHEN P. MOWEN COMPANY
(WILLIAM F. WOODEM, Successor)

ADDRESS 108 W. NORTH AVE

Payne.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69438

CERTIFICATE OF DEATH.

74-001 D69438

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 McCulloh ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev Caleb Payne

(a) RESIDENCE. NO. 1200 McCulloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster County Va

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Daniel Ringgold (Address) 1200 McCulloh st

15 Filed ..... 19 ..... Registrar

NOV 24 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1922 to Nov 23, 1922, that I last saw he alive on Nov 22, 1922, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Not known

(duration) yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Symptoms

(Signed) Chas H Fowler M. D.

Nov 23 1922 (Address) 712 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL 11/27/22 19

20 UNDERTAKER Sam'l H Chaseison

ADDRESS 1420 Harlem st

A. B. C. Physicians: Please fill in all items carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. & Ord. No. 2000 Bks.

D69439

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 29

D69439

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2460 Buchanan ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Kershman

(Residence in Baltimore: No. 2460 Buchanan Street; 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	M

6-DATE OF BIRTH, ... (Month) ..... (Day) 1877 (Year)

7-AGE,	If LESS than 1 day,
50 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Saloon
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Keeper

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Jack Lewis

(Address) ..... 1439 E Balto St

15-

Filed NOV 24 1922, 191.....

ROBERT R. KRAUTH
Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 24 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 22 1922, to Nov 24 1922, that I saw h[im] alive on Nov. 24 1922, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Chronic

Nephritis

2

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia Coma

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Frank N. Smith M. D.

Nov. 24, 1922. (Address) 917 E. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Hebrew Herring Run	11-27-1922
20-UNDERTAKER Jack Lewis	ADDRESS 1439 E Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69440

CERTIFICATE OF DEATH.

162 D69440

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 Division St. 14 WARD)

2-FULL NAME Jeanette Johnson

(a) RESIDENCE. NO. 1420 Division ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 11, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wallace Johnson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Augusta Davis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Wallace Johnson
(Address) 1420 Division St

15 Filed NOV 24 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1922, to Nov 22, 1922, that I last saw her alive on Nov 22, 1922, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage - Umbilical Cord

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Norwood Wilson M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 24 1922
20 UNDERTAKER	ADDRESS
Edward Ruggold	1463 W Lay

NOTE—Items 1 to 15, inclusive, must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 89 D69441

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 907 N. Fulton Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Louise Ritz

(Residence in Baltimore: No. 907 N. Fulton Ave St.; yrs. 14 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word): Single

6-DATE OF BIRTH: Nov. Dec. ? (Month) (Day) 1872 (Year)

7-AGE: 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Ga.

PARENTS.

10-NAME OF FATHER: Wm. Folland

11-BIRTHPLACE OF FATHER, (State or Country): Ga

12-MAIDEN NAME OF MOTHER: Dk

13-BIRTHPLACE OF MOTHER, (State or Country): Dk.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Ritz

(Address) 907 N. Fulton Ave

15- Filed NOV 24 1922 NOV 24 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov. (Month) 22 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Nov. 24 1922 (Address) 2502 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: Nov 24 1922

20-UNDERTAKER: Putnam & Coe

ADDRESS: 1723 Lafayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69442

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 D69442

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 7 S. Stricker St.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Brown

(a) RESIDENCE. No. 7 S. Stricker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 6 mos. 28 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Elizabeth Brown

6 DATE OF BIRTH (month, day, and year): Apr. 25 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~73~~	73	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired B & O. Railroad clerk

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

809

9 BIRTHPLACE (city or town) (State or country): Balto - Md.

PARENTS

10 NAME OF FATHER: Samuel Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Sarah Elizabeth Brown 7 S. Stricker St.

15 Filed . 19 NOV 24 1922

ROGER R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov-22. 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct-13 . 1917 . to Nov 22 . 1922, that I last saw him alive on Nov-22 . 1922, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis.

(duration) ✓ yrs. ✓ mos. 5 ds.

CONTRIBUTORY (Secondary): Arthritis Deformans & Senile Arteriosclerosis

(duration) over 5 yrs. ✓ mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry E. Ohlen M. D.

. 19 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Nov 25 1922

20 UNDERTAKER: H. H. Wittke

ADDRESS: 1131 W Lombard St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69443

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Sauerwald

(a) RESIDENCE NO. 1536 Abbotts ton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: August C. Sauerwald

6 DATE OF BIRTH (month, day, and year): March 14, 1896

7 AGE — Years: 26 — Months: 8 — Days: 11 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Alabama

PARENTS

10 NAME OF FATHER: — McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country): Alabama.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mrs. August C. Sauerwald

(Address) 1536 Abbotts ton St

15 Filed . 19 Robert P. Harrison, Registrar

NOV 24 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1922 to Nov. 24, 1922

that I last saw her alive on Nov. 24, 1922

and that death occurred, on the date stated above, at 2 55 A m.

The CAUSE OF DEATH* was as follows:

Inflammation - Tuberculosis - death 7 Chest in utero 9 yrs - 11 mos pregnancy.

(duration) yrs. mos 10 ds.

CONTRIBUTORY = Malnutrition -
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov 19-22 Caesarian Section.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George E. Shannon, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemy — DATE OF BURIAL: Nov. 27 1922

20 UNDERTAKER: Henry Heck & Son — ADDRESS: 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69444

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69444

CERTIFICATE OF DEATH.

161-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Infant Foster

(Residence in Baltimore: No. Wesleyan, Sparrows P. Rd. St.; yrs.,.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

79

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) [illegible]

6-DATE OF BIRTH. Nov. (Month) 18 (Day) 1922 (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 21 hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS:

10-NAME OF FATHER. Albert Foster

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER. Louise Minor

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hosp.

(Address).....

15-

Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

19686

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 19 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature birth - about seven months gestation lived 21½ hrs

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) J. H. Walker M. D. (Coroner.)

11-21 1922 (Address) 508 E. Monument

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ...19...

20-UNDERTAKER. Commissioner Health.

ADDRESS

NOV 23 1922

Per Wm. B. WOODALL

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69445 D69445

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 Braddish Ave St., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wesley ~~Hammond~~ Webb

(a) RESIDENCE. No. 1500 Braddish Ave St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred + yrs. 5 mos. — ds. How long in U. S., if of foreign birth? X yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) July 5, 1877.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) General farming.

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Friendship, Md.

PARENTS

10 NAME OF FATHER Hamilton G. Webb.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co., Md

12 MAIDEN NAME OF MOTHER Josie E. Plummer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co., Md.

14 Informant Mrs. F. A. Trout, (Address) 1500 Braddish Ave. Balto. City.

15 Filed Nov. 24 1922 Robt. P. Garrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23rd 1922.

17 I HEREBY CERTIFY, That I attended deceased from July, 1922. to Nov. 23rd, 1922.
that I last saw him alive on Nov. 23rd, 1922.
and that death occurred, on the date stated above, at 10:15 P. m.
The CAUSE OF DEATH* was as follows:
Tubercular enteritis.

(duration) 2 yrs. + mos. + ds.

CONTRIBUTORY (Secondary) X
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Friendship Md.
Did an operation precede death? Yes Date of July 1/22.
Was there an autopsy? No.
What test confirmed diagnosis? Operation July 1/22.
(Signed) O. S. Hoffman, M. D.
19 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friendship Cemetery, Friendship a.a.Co. Md.
DATE OF BURIAL: Nov. 26, 1922

20 UNDERTAKER: George J. Smith
ADDRESS: 1532 Hollins St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69446

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69446

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1426 N. Gilmor St. ST., 15 WARD)

2-FULL NAME E. Ardean Ring Eisel

(a) RESIDENCE NO. 1426 N. Gilmor St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Eisel

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
37	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Anne Arundel Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER John W. Ring

11 BIRTHPLACE OF FATHER (city or town) Baltimore Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth A. King

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant George W. Eisel
(Address) 1426 N. Gilmor St.

15 Filed NOV 24 1922, 19 ..... Robert P. Garrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23" 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to Nov 23, 1922,
that I last saw h.. alive on Nov 22, 1922
and that death occurred, on the date stated above, at 1.30A m.
The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones, M. D.

11/23/22 (Address) Augusta & Frederick Aves.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Loudon Park Cemetery — Nov 25" 1922

20 UNDERTAKER — ADDRESS
Joseph D. Cook — 1003 N. Ballo St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

See Letter Attached ✓

Spec. 6-9-19 H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69447

D69447

CERTIFICATE OF DEATH.

90

REGISTERED NO. 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 N. Rose ST.: WARD)

2-FULL NAME George William Smith

(a) RESIDENCE. NO. #403 N. Rose ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Smith 1865

6 DATE OF BIRTH (month, day, and year): March 13-1857

7 AGE: Years 65 Months 8 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Buyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: W. H. Killian

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Nicholas Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Bentzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Elizabeth Smith 403 N. Rose St

15 Filed 1922 . 19 Robert P. Harris Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 22 1922

17 I HEREBY CERTIFY, That I attended deceased from November 19 1922 to November 22 1922 that I last saw him alive on November 22 1922, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Geyer, M. D.

. 19 (Address) 541 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: Nov 26 1922

20 UNDERTAKER: Wm C. Killian

ADDRESS: 233 N. Jefferson St

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The questio... applies to each and every person, irrespectiv... or ter... *Farm... tect, I... firema... trial ... kind o... or ind... vided ... when ... *mill;* ... *Auto...* form ... "Labo... witho... *Farm...* home; ... only ... salar... or *At... At s...* repor... in d... *Hous...* or giv... state... from ... *Farm...* occup...

PHONE WOLFE 2198
OFFICE HOURS:
8 TO 10 A. M.
6 TO 8 P. M.
SUNDAY MORNING ONLY

DR. WM. G. GEYER
CORNER
MILTON AVE. & McELDERRY ST.

REG NO 7074 DATE

℞ NAME

ADDRESS

December 2-1922

Mr J. Hampton Jones
Commissioner of Health.

Dear Sir:-

Please to certify
incorrect age of Mrs. George W. Smith
#403 N. Rose St. as stated on death
Certificate. The correct age of Mrs Smith
is 57yrs-8 mos. 9 days instead of 65 yrs.
Hoping you will kindly rectify
this error.

Yours truly,

W. Hampton Geyer M.D.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease ...*nia* (second... ...s or terminal ...*ia*" (merely ...Coma,""Con... ...enile," etc.), ...e," "Hemor... ...ge,""Shock," ...finite disease ...*rs* qualify all ...scarriage, as ...*peritonitis*," ...peration was ...E MEANS OF ...SUICIDAL, or ...mpossible to ...*dental drown... ...nt; Revolver ...carbolic acid* ...ne injury, as ...e. g., *sepsis*, ...of "contribu... ...t of cause of ...nclature of

...ATEMENTS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69448 D69448

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Martha Ritter

(a) RESIDENCE NO. 2323 Mc Elderry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): July 10 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76.	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Boetimus Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital Balto Md

15 Filed ..... 19 ..... Registrar

Robert F. Garrison
Burial Permit Clerk.

NOV 21 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 23 1922 to Nov 23 1922

that I last saw her alive on Nov 23 1922

and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Senile Cataracts

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? General Paralysis

(Signed) N. Goldsmith Jones M. D.

11/24/1922 (Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: Nov 22 1922

20 UNDERTAKER: Chas C Miller — ADDRESS: 2034 Aisquith St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69449

D69449

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 604 W Lombard ST., 4 WARD)

2-FULL NAME Virginia M. Mummert

(a) RESIDENCE NO. 604 W Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 3 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~ Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29-1919

7 AGE 3 Years 3 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Mummert

11 BIRTHPLACE OF FATHER (city or town) (State or country) N-Carolina

12 MAIDEN NAME OF MOTHER Theresa Lantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Mrs Mummert 604 W Lombard St.

15 Filed , 19 Registrar

NOV 24 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/22 19 22

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21st, 1922, to Nov. 22nd, 1922, that I last saw her alive on Nov. 22nd, 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia (Fulminating Type) over

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Convulsions 4 hours

(duration) — yrs. — mos.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Kleibel M.D.

11/22/1922 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emanuel Cemetery

DATE OF BURIAL Nov 25 1919

20 UNDERTAKER Jas C. Miller

ADDRESS 2334 Jeffers

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D69450

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69450

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Marlborough Apts. (ST.) 6C. (WARD)

2-FULL NAME Simon Blumenthal

(a) RESIDENCE. NO..... Marlborough Apts. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Com. Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Bernhardt Blumenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Janetta Stern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Edw. Blumenthal Marlborough Apts.

15 Filed 19 Robert P. Harrison Registrar

NOV 24 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24/ 1922.

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1922, to Nov 23, 1922, that I last saw h im alive on Nov 23, 1922, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) over 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Harry Adler, M. D.

, 19 (Address) 1718 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oheb Sholom Cem.	11/26/ 1922
20 UNDERTAKER David Sondheim	ADDRESS 1118 W. Mt. Royal Ave.

X

Mrs. Edw. Blumenthal

Marlborough Apts.

NOV 24 1922

Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D69450

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69450

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Marlborough Apts. (ST.) 6C. (WARD)

2-FULL NAME Simon Blumenthal

(a) RESIDENCE. NO..... Marlborough Apts. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Com. Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Bernhardt Blumenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Janetta Stern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Edw. Blumenthal Marlborough Apts.

15 Filed 19 Robert P. Harrison Registrar

NOV 24 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/24/ 1922.

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1922, to Nov 23, 1922, that I last saw h im alive on Nov 23, 1922, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) over 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Harry Adler, M. D.

, 19 (Address) 1718 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oheb Sholom Cem.	11/26/ 1922
20 UNDERTAKER David Sondheim	ADDRESS 1118 W. Mt. Royal Ave.

IMPORTANT. WITH CERTIFICATE OF DEATH PHYSICIANS SHOULD BE CAREFUL TO SEE THAT THE INFORMATION IS AS COMPLETE AS POSSIBLE. NAME should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69451

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69451

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 Marshall ST., 23 WARD)

2-FULL NAME Chas. J. Steinw

(a) RESIDENCE NO. 1430 Marshall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Steinw

6 DATE OF BIRTH (month, day, and year) 1871.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Muth Bros.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adolph Steinw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Breitenbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emil Steinw

(Address) 1430 Marshall St.

15 Filed NOV 25 1922, 19 Robert P. Carrick, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1922, to Nov 23, 1922

that I last saw him alive on Nov 22, 1922,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cardiac thrombosis

5 Months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. F. Hopkins, M. D.

Nov 24 1922 (Address) 1 E Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cem

DATE OF BURIAL Nov. 25 1922

20 UNDERTAKER Margaret J. Flynn

ADDRESS 1422 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69452

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69452

CERTIFICATE OF DEATH.

Registered No. C 19179

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ivan B. Edwards.

8

(Residence in Baltimore: No. 1701 Hollins St. St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. May 6th. 1892. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
30 yrs. 6 mos. 16 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Brakesman,
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R. Co.

9-BIRTHPLACE, (State or Country). Charlestown, W. Va.

PARENTS.

10-NAME OF FATHER. Bates Edwards.

11-BIRTHPLACE OF FATHER, (State or Country). West Virginia.

12-MAIDEN NAME OF MOTHER. Kate Brillhart.

13-BIRTHPLACE OF MOTHER, (State or Country). West Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Ava Edwards, (wife)

(Address) 1701 Hollins St.

15-

Filed ..... 192.....

Registrar.

Robert P. Harrison,
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. November 22nd. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally burned about the body and limbs by ignition of gasoline.

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Eisenhardt M. D. (Coroner.)

Nov. 24 192 22 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Port Ave. & Lawrence St. Nov. 2nd. 1922.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Frederick Md. DATE OF BURIAL. Nov. 25 1922

20-UNDERTAKER. Margaret B. Flynn ADDRESS 1422 Light St

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69453 D69453

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Race st. ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elisabeth Biemillér

(Residence in Baltimore: No. 1017 Race st. St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 16/1861., 1 (Month) (Day) (Year)

7-AGE, 61 yrs. 5 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House-work.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Melchior Jordan

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Gertrude Riefer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Biemiller

(Address) 1017 Race st.

15-

Filed....., 191.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 23/22., 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 21/22. 191, to Nov. 23/22. 191, that I saw her alive on Nov. 22/22. 191, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

.....

.....

Acute dilitation of heart.

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Acute catharral jaundice.

..... (Duration).....yrs. mos. 2 ds.

(Signed) Henry Wade Thomas M. D.

Nov. 24/22. (Address) 933 Hanover st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Nov. 27th, 1922

20-UNDERTAKER E. Schlosman & Son ADDRESS 1039 Hanover st

D69454 HEALTH DEPARTMENT—CITY OF BALTIMORE D69454

CERTIFICATE OF DEATH.

188-003

1-PLACE OF DEATH En route to

City of BALTIMORE: (No. South Baltimore General Hospital Ward) 25

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lanston Hall.

(Residence in Baltimore: No. 521 Maryland Ave. Brooklyn. St.; yrs. 14 mos. ---- ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. February 19th. 1916.
(Month) (Day) (Year)

7-AGE. 6 yrs. 9 mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country). Birmingham England.

PARENTS.

10-NAME OF FATHER. Lees Hall.

11-BIRTHPLACE OF FATHER. (State or Country). England.

12-MAIDEN NAME OF MOTHER. Mable Statham.

13-BIRTHPLACE OF MOTHER. (State or Country). England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lees Hall. (father)

(Address) 521 Maryland Ave. Brooklyn.

15- Robert P. Harrison,

Filed ..... 192 ..... Registrar.

Nov 25 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23rd. 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Automobile accident.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Nov. 24 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Patapsco Ave. near 4th. St. Brooklyn.

[redacted] November 23rd. 1922

19-PLACE OF BURIAL OR REMOVAL. Cedar Hill Cem. DATE OF BURIAL. Nov 25 1922

20-UNDERTAKER. Mrs J E Evans & Sons ADDRESS 1428 E. Charles St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69455

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69455

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 146 W Hamburg (ST.) 23 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Goutt

(a) RESIDENCE. NO. 146 W. Hamburg ST. 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Goutt

6 DATE OF BIRTH (month, day, and year) 1818

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Helper

(c) Name of employer Brano Foolery

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

11 Informant (Address) Victoria Goutt 146 W Hamburg St

15 Filed 19 Registrar

Robert P. Harman, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/23/1922

17 I HEREBY CERTIFY, That I attended deceased from 11/15/22 to 11/23/22 that I last saw h alive on 11/22/22 and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Burial Registration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cut throat wounds of Arthur Sabrain (duration) about 1 mos. ds.

18 Where was disease contracted if not at place of death? (Was operation performed?) None —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. Guy Bowley, M. D.

11/23/1922 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 26 1922
20 UNDERTAKER	ADDRESS
Jno. H. Toadvine	142 W. Hill St

U. S. E.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 23 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69456

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69456

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 Wayne ST.: 22 WARD)

2-FULL NAME Dora Brooks

(a) RESIDENCE. No. 608 Wayne ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (Write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): May 20 1885

7 AGE — Years: 35 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Factory

(c) Name of employer: Standard Oil Co.

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Thomas Gantt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Victoria Clarke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Victoria Gantt

(Address) 146 N Hanover St.

15 Filed ..... 19 .....

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/22/1922

17 I HEREBY CERTIFY, That I attended deceased from 11/9/22, to 11/22/22, that I last saw her alive on 11/22/22, and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) Acute yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Acute Eczema & Bronchitis (duration) about yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Lung Dowley, M. D.

, 19 (Address) 908 Shawan Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 26 '22
20 UNDERTAKER	ADDRESS
Jno. H. Toadvine	W. Fayette St

NOV 25 1922

1. NAME LEGIBLY, WITH PENCIL OR INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69457

CERTIFICATE OF DEATH.

38 V

D69457

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 551 W. Barre ST., 12 WARD)

2-FULL NAME Della Hill

(a) RESIDENCE NO. 551 W. Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Hill

6 DATE OF BIRTH (month, day, and year): Apr, 27, 1877

7 AGE: Years 45 | Months 6 | Days 28 | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Private Homes

9 BIRTHPLACE (city or town): Fredricksburg

(State or country): Virginia

PARENTS

10 NAME OF FATHER: Ruben Thornton

11 BIRTHPLACE OF FATHER (city or town): Fredricksburg

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Anna ——

13 BIRTHPLACE OF MOTHER (city or town): Fredricksburg

(State or country): Virginia

14 Informant: Ida Hill

(Address): 315 Otterbein St

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov, 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov, 14, 1922, to Nov, 24, 1922,

that I last saw her alive on Nov, 22, 1922,

and that death occurred, on the date stated above, at 3:10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Acute and mitral Endocarditis (ill 2 months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) David Franklin, M. D.

11/24, 1922 (Address) 1212 W See St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Nov 27 1922

20 UNDERTAKER: Jno. H. Toadvine — ADDRESS: 142 W. Hill St

NOV 27 1922

Postal Permit Clerk

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Syphilis

D69458

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69458

CERTIFICATE OF DEATH.

129

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2905 Almeda Boulevard St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Marie Stohrman

(Residence in Baltimore: No. 2905 Almeda Boulv St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Oct (Month) 10 (Day) 1901 (Year)

7-AGE. 22 yrs. 1 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Fredrick W. Stohrman

11-BIRTHPLACE OF FATHER, (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Caroline C Bauerschmidt

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F W Stohrman Father

(Address) 2905 Almeda Boulv

15-

Filed ..... 192.....

Robert P. Barrison, Burial Permit Clerk

Registrar.

N 25 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 22 (Month) (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilitation - Pulmonary Oedema

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 5 yrs. ....mos. ....ds.

(Signed) J. H. H. Colter M. D.
(Coroner.)

Nov 24 1922 (Address) 508 E North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Lorraine Cemtery	Nov. 25 1922

20-UNDERTAKER.	ADDRESS
William G Schaeffer	1816 Monument

Spec.—1-10-21—M&T—1500 Bks.

D69459

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69459

CERTIFICATE OF DEATH.

101-001

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST., (No) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence E. Willis

(a) RESIDENCE NO. Bay View Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Bernard Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Emma Hart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1920, to Nov. 23, 1922.

that I last saw h alive on Nov. 23, 1922.

and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? M.T.H.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frances L. Bradshaw, M. D.

11-23-22, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Lane

DATE OF BURIAL Nov 25, 1922

20 UNDERTAKER Potts Burgess & Love

ADDRESS Govanstown

Dep't Registrar

NOV 25 1922 Vital Records Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69460 ✓ D69460

57

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green St. 19 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida V. Stubbs

(a) RESIDENCE. No. 225 N. Calhoun St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilbur F. Stubbs

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Md

PARENTS

10 NAME OF FATHER Mr. Pledge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Louise M. Stubbs

(Address) 1706 Eutaw Place

15 Filed ..... 19 ..... Registrar

NOV 25 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/23 1922

17 I HEREBY CERTIFY, That I attended deceased from 11/22, 1922, to 11/23, 1922, that I last saw her alive on 11/23, 1922, and that death occurred, on the date stated above, at 8 55 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Diabetes Mellitus

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Leon Friedman, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov. 25 1922
20 UNDERTAKER John O. Mitchell	ADDRESS 1201 W. Fayette St.

S. 8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69461

HEALTH DEPARTMENT—CITY OF BALTIMORE

52

D69461

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1024 Homewood Ave ST., 10 WARD)

2-FULL NAME Valentine Cioffe

(a) RESIDENCE NO. 1024 Homewood Ave ST., 10 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Bena Cioffe

6 DATE OF BIRTH (month, day, and year) Dec. 24 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce dealer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Ferdinand Cioffe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Nellie Teano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs Bena Cioffe (Address) 1024 Homewood Ave

15 Filed ....., 19.... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1922, to Nov 24, 1922, that I last saw h— alive on Nov 24, 1922, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. — mos — ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. H. Wentz M. D.

Nov 25, 1922 (Address) 1408 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 27 1922
20 UNDERTAKER Henry Hoeck Son	ADDRESS 1801 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Robert F. Barrett, Clerk
Burial Permit Clerk.

D69462

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69462

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 346 S. Stricker St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gottfried Rathgeber

(Residence in Baltimore: No. 346 S. Stricker St.; yrs. 60 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. Jan (Month) 28 (Day) 1843 (Year)

7-AGE. 79 yrs. 9 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cabinetmaker
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Gottfried Rathgeber

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine Ernold

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Eckert

(Address) 1828 Eagle St

15-

Filed..... 192.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 13 (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

Sudden

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. ....mos. ....ds.

(Signed) James McJenkin M. D. (Coroner)

Nov 14 192.2 (Address) 704 E Chase

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Nov 27, 1922

20-UNDERTAKER, C. W. Dill — ADDRESS 3109 Fredk. Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D69463

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69463

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 S. Highland Ave ST., 76 WARD)

2-FULL NAME Anna Greif

(a) RESIDENCE NO. 422 S. Highland Ave ST., 76 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... None.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Bernard Greif

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Groom

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Bernard Greif
(Address) 422 S. Highland Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1922, to Nov 23, 1922

that I last saw him alive on Nov 22, 1922

and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY
(Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edgar V Staley, M. D.

Nov 24, 1922 (Address) 1 a W. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Nov. 26 1922

20 UNDERTAKER Lilly & Zeile

ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 25 1922 Health Dept. of Baltimore, Permit Clerk

Spec.—1-10-21—M&T—1500 Blks.

D69464

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69464

CERTIFICATE OF DEATH.

160

1-PLACE OF DEATH St Vincents 2nft Asy.

CITY OF BALTIMORE: (No. 1401 — Division ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Bitzelberger

(a) RESIDENCE NO. 3708 Foth Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Bitzelberger

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Barbara Kramer

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant John Bitzelberger (Address) 3708 Foth Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1922 to Nov. 23, 1922

that I last saw her alive on Nov. 23, 1922

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) yrs. 2 mos 2 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough, M. D.

, 19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Nov. 26 1922

20 UNDERTAKER Lilly & Zeile ADDRESS 403 S. Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

V 25 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69465

CERTIFICATE OF DEATH.

75-002 D69465

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2927 Harlem Ave. ST., 16 WARD)

2-FULL NAME Emma E. Fennert

(a) RESIDENCE NO. 2927 Harlem Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct. 1st 1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
68	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Fennert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Bradt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Fisher (Address) 2927 Harlem Ave

15 Filed ....., 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 23rd 1922

17 I HEREBY CERTIFY, That I attended deceased from ....., 1920, to Nov 21, 1922.

that I last saw her alive on Nov 21, 1922

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) 2 yrs. mos ds.,

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. A. Smith, M. D.

, 19 (Address) 541 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Loudon Park

DATE OF BURIAL Nov. 25th 1922.

20 UNDERTAKER Wm. & Chas. J. Kemp & Son

ADDRESS 801 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 25 1922

Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Blks.

159392
D69466

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D69466

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp, ST., 6 WARD)

2-FULL NAME Baby Weaver

(a) RESIDENCE No. 1922 E. Fayette St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND~~ or ~~WIFE~~ of James A. Weaver (father)

6 DATE OF BIRTH (month, day, and year) Oct. 29, 1922.

7 AGE — Years — Months 25 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER James A. Weaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) .....

12 MAIDEN NAME OF MOTHER Isabelle Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant (Address) Johns Hopkins Hospital, Records.

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1922.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1922, to Nov. 24, 1922, that I last saw her alive on Nov. 24, 1922, and that death occurred, on the date stated above, at 6.20 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) — yrs. — mos 26 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) — yrs. — mos. 26 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Nov 25 1922

20 UNDERTAKER J. G. Moran

ADDRESS 300 E Baltimore.

NOV 25 1922 Burial Permit Clerk

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69467

CERTIFICATE OF DEATH.

99-002

D69467

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 W. Pratt St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Frederick Retter.

(a) RESIDENCE NO. 1424 W. Pratt St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced (or) WIFE of HUSBAND of Katerine Retter

6 DATE OF BIRTH (month, day, and year) March 23, 1840.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	82	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Retter.

11 BIRTHPLACE OF FATHER (city or town) Germany. (State or country)

12 MAIDEN NAME OF MOTHER Sophia Steffers.

13 BIRTHPLACE OF MOTHER (city or town) Germany. (State or country)

14 Informant Annie Hebler. (daughter)

(Address) 1424 W. Pratt St.

15 Filed ....., 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Novemb, 24 1922

17 I HEREBY CERTIFY, That I attended deceased from November 18, 1922, to November 24, 1922, that I last saw h... alive on November 28, 1922, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of the Lungs.

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? -------

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis

(Signed) Chas. M. Reinhardt, M. D.

11/24/22 (address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 11/27 1922

20 UNDERTAKER Chas. P. Evans & Son

ADDRESS 1814 E. Royal Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69468

CERTIFICATE OF DEATH.

100-001 D69468

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospitals ST. 14 WARD)

2-FULL NAME Deborah Waters

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857 (?)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) H. P. Scott

15 Filed ....., 19 ..... Registrar

Robert E. Harrison,

NOV 25 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 20, 1922, to Nov 23, 1922.

that I last saw h[illegible] alive on Nov 23, 1922.

and that death occurred, on the date stated above, at 5:00 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Aut

(Signed) Clyde M. Miller, M. D.

11 Nov 1922 (Address) Municipal Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	Nov 27 1922
20 UNDERTAKER	ADDRESS 378
Samuel Hendley & Bro	

Spec.—1-10-21—M&T—1500 Bks.

D69469

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69469

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 21 WARD)

2-FULL NAME Albert Sanders

(a) RESIDENCE NO. 100 Reisa Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Carrie Sanders

6 DATE OF BIRTH (month, day, and year): Oct 16-69

7 AGE — Years: 53 Months: 1 Days: 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): Letter Carrier

(c) Name of employer: U.S.P.O.

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Geo. W. Sanders

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Catherine —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Linden L. Sanders

(Address): 201 Hamilton Ter.

15 Filed ..., 19... Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1922, to Nov. 22, 1922, that I last saw h— alive on Nov. 22, 1922, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis Interstitial
Chronic

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Louis Hubert Adkinson, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: 11/25 1922

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69470

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69470

REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 558 Mosher St.: 14 (Ward)

2-FULL NAME Infant of Chas. E. & Blanche A. Johnson

(a) RESIDENCE. No. 558 Mosher St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C	SINGLE

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-20-22

7 AGE	Years	Months	Days	If LESS than ~~1 day~~ 6 hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas. E. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Blanche Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co Md

14 Informant Chas. E. Johnson
(Address) 558 Mosher St.

15 Filed . 19 . Registrar

NOV 25 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-23 1922

17 I HEREBY CERTIFY, That I attended deceased from ..... 19 . to . 19 .

that I last saw him alive on 11-21 1922,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William A Harris, M. D.

11/23 1922 (Address) 1200 Penn. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Nov. 24 1922

20 UNDERTAKER: Jno. W. Johnson — ADDRESS 1234 Ostrey St.

CN. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69471

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

D69471

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1015 Greenmount ave WARD 10)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Georgiana Parrish

(Residence in Baltimore: No. 1015 Greenmount ave St.: 68 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Dec 17 (Month) (Day), 1853 (Year)

7 AGE: 68 yrs. 10 mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House
(b) General nature of industry, business, or establishment in which employed (or employer): Work

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Theodore Vietch

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: dont Know

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Gordon

(Address) 1015 Greenmount ave

15.

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov (Month) 24 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18, 1922, to Nov 24 1922, that I saw her alive on Nov 24, 1922, and that death occurred, on the date stated above, at 5 0 m.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) ..... yrs. ..... mos. 6 ds

Contributory (SECONDARY) arteriosclerosis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) James McHenry M. D.

Nov 25, 1922 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Baltimore

DATE OF BURIAL: Nov 27, 1922

20 UNDERTAKER: H. C. Wisefield

ADDRESS: 914 Greenmount ave

NOV 25 1922

Spec.—1-10-21—M&T—1500 Blks.

D69472

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69472

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hosp ST., 330 WARD)

2-FULL NAME Mrs. Margaret Shanahan

(a) RESIDENCE NO. 4 South Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Shanahan

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Patterson

11 BIRTHPLACE OF FATHER (city or town) Knock (State or country) Millstown Co Galway Ireland

12 MAIDEN NAME OF MOTHER Mary Dorenady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John J. Shanahan (Address) 4 S. Pulaski

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 17, 1922, to Nov 23, 1922,

that I last saw h. alive on Nov 23, 1922,

and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism —

over

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not applic

Did an operation precede death? yes Date of Oct 19/22

Was there an autopsy? no

What test confirmed diagnosis? Obstruction of Artery

(Signed) C. J. Pulaski M. D.

, 19 (Address) Bon Secours Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	11/27/22
20 UNDERTAKER	ADDRESS
F. A. Staley	Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 25 1922

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pneumonia Postoperative
Patient was 36 days post operative. Operation was perineal repair for cystocele & rectocele. Had had two attacks of severe right sided pain with one attack of rusty sputum & fever for two days. Present attack occurred suddenly & is dyspnoea cyanosis & failure

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69473

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

D69473

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Little Sisters of the Poor. ST.: 10 WARD)

2-FULL NAME Katherine Hutchinson.

(a) RESIDENCE. NO. Preston Valley. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ellicott City
(State or country) Md

PARENTS

10 NAME OF FATHER Arthur Hutchinson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Ellen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Little Sisters of the Poor.
(Address) Preston Valley

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1932

17 I HEREBY CERTIFY, That I attended deceased from No record . 19 . to . 19 .

that I last saw her alive on Nov 23 . 1932 .

and that death occurred, on the date stated above, at 2. a. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Nov (Signed) F. A. Warna, M. D.

24 . 19 32 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	11/27/32

20 UNDERTAKER F. A. Farley Sattler ADDRESS Fayette

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69474

CERTIFICATE OF DEATH.

100-001

D69474

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1222 Ruter ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Norman Marshall

(a) RESIDENCE. NO. 1222 Ruter ST., WARD.

(Usual place of abode) (if nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 6, 1922

7 AGE: Years 3 Months Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Louisa Lancaster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wash. D.C.

14 Informant: Louis Marshall (Address) 1222 Ruter St.

15 Filed . 19 Registrar

Robert E. Harrison

NOV 25 1922

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/24/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 11/23/ 1922 to 11/24/ 1922

that I last saw him alive on 11/23/ 1922

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Primary) 5 ds.

(duration) yrs. mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Hopkins M. D.

1922 (Address) 1216 D. H. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Nov 25, 1922

20 UNDERTAKER: Daniel Easton

ADDRESS: Balto

S. R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

69475 D69475

HEALTH DEPARTMENT—CITY OF BALTIMORE

69475 D69475

CERTIFICATE OF DEATH.

167

19

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1851 Ramsey St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachael E. D. Clark

(Residence in Baltimore: No. 1851 Ramsey St.; yrs., 12 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: April (Month) 18 (Day) 1850 (Year)

7-AGE: 66 yrs. 7 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home work
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country): Harford Co Md

PARENTS:

10-NAME OF FATHER: Wm J. Davis

11-BIRTHPLACE OF FATHER, (State or Country): Harford Co Md

12-MAIDEN NAME OF MOTHER: Ann Watkins

13-BIRTHPLACE OF MOTHER, (State or Country): Harford Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. D. Fulton

(Address) 3108 Greenmount Ave

15-

Filed NOV 26 1922 ROBERT R. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov (Month) 24 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas Suicide

(Duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary) Mentally unbalanced

(Duration) yrs. mos. ds.

(Signed) James M. Newbold M. D. (Coroner.)

Nov 25 1922 (Address) York & Chase Sts

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Slate Ridge Church Cem. DATE OF BURIAL: Nov. 26th 1922

20-UNDERTAKER: Wilbur W. Shriver ADDRESS: 1018 Edmondson Ave.

Spec.—1-10 21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69476

CERTIFICATE OF DEATH.

90 D69476

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 Beechdale Road, ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Frances Marchant

(a) RESIDENCE NO. 110 Beechdale Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Marchant

6 DATE OF BIRTH (month, day, and year) Aug. 25, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	2	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mathews County Virginia

PARENTS

10 NAME OF FATHER John Forrest

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Clarence R. Marchant (Address) [illegible] Beechdale Road

15 Filed NOV 26 1922, 19 ROBERT R. [illegible] Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7 1922, to Nov. 24 1922, that I last saw h[illegible] alive on Nov. 24 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows: Pneumonia, Entrohm

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation (duration) 4 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. J. Perlis, M. D.

11/25 1922 (Address) 732 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mathews County, Va. DATE OF BURIAL 11/26 1922

20 UNDERTAKER Henry [illegible] Weare & Son ADDRESS 805 N. Calvert

Via. Md. Del. & Va Railway - Clarence R Marchant Escort

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69477 10 D69477

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 24 WARD)

2-FULL NAME Miriam Slater

(a) RESIDENCE. No. 1825 Bank ST., 2 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 18 - 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Elmer Slater

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Knolsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Elmer Slater (Father)

(Address) 1830 Bank St.

15 Filed NOV 26 1922 19 Burial Permit Clerk Registrar

ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1922, to Nov 25, 1922, that I last saw h[illegible] alive on Nov 25, 1922, and that death occurred, on the date stated above, at 9:10 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Nov 25 tracheotomy.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B Macgowan, M. D.

11/25/22 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivett Cemetary

DATE OF BURIAL: Nov. 26 1922

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 403 S. Mo[illegible]

Spec.—1-10-21—M&T—1500 Bks.

Hardy.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69478

CERTIFICATE OF DEATH.

128 D69478

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 N Bonner ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ada Meade Hardy

(a) RESIDENCE NO. 324 N Bonner ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William L. Hardy

6 DATE OF BIRTH (month, day, and year) June 15, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	38	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 0 70

(b) General nature of industry, business, or establishment in which employed (or employer) General house work

(c) Name of employer Ray work

9 BIRTHPLACE (city or town) Relay Md.
(State or country) Baltimore Co

PARENTS

10 NAME OF FATHER Rev. Alex Snowden

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Catonsville Md.

12 MAIDEN NAME OF MOTHER Annie E. Hopkins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Relay Md. Balto Co Md

14 Informant Mary L. Simmons (Sister)
(Address) 16 E. W. Lexington

15 Filed NOV 26 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-23-22 19

17 I HEREBY CERTIFY, That I attended deceased from 11-7 19 22, to 11-23 19 22, that I last saw h[illegible] alive on 11-23 19 22, and that death occurred, on the date stated above, at 12.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis (Cor.)

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) [illegible] M. D.

19 (Address) 2106 Multiby Ft

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lowndensville, Md. DATE OF BURIAL Nov. 26 19 22.

20 UNDERTAKER Mrs. Kate R. Williams ADDRESS 1114 W. Saratoga St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69479

CERTIFICATE OF DEATH.

101-001 D69479

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Markel

(a) RESIDENCE. No. 1715 N. Smallwood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER John Markel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Mrs. Lena Markel 1715 N. Smallwood St.

15 Filed NOV 26 1922, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1922, to Nov. 24, 1922, that I last saw him alive on Nov. 24, 1922, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Organism not determined)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Moses Gellman, M. D.

11/24 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd.

DATE OF BURIAL Nov. 26 1922

20 UNDERTAKER A. Lissner & Bro

ADDRESS 1127 E Balto St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69480

D69480

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56, REGISTERED NO.

CITY OF BALTIMORE: (No. FORT MCHENRY, BALTO., MD. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME DIXON, Walter

(a) RESIDENCE No. 1021 S. Howard St., Baltimore, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teamster

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): -- Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): -- Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown --

14 Informant: Hospital Records

(Address): Fort McHenry, Md.

15 Filed ..... , 19 .... (Registrar)

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2 , 1922 , to Nov. 22 , 1922 , that I last saw him alive on Nov. 22 , 1922 , and that death occurred, on the date stated above, at 9:10 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 3 yrs. - mos - ds.

CONTRIBUTORY (Secondary) Chr. passive congestion lungs

(duration) 3 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. O. Kuss M. D.

Surgeon (R) U.S.P.H.S.

Nov. 22 1922 (Address) U.S. Veterans' Hosp. #56, Fort McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Amt

DATE OF BURIAL: Nov. 27 1922

20 UNDERTAKER: L. Lurman & Bro

ADDRESS: 112 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69481

CERTIFICATE OF DEATH.

57 D69481

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 N. Poppleton St. ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Scherr

(a) RESIDENCE. NO. 109 N. Poppleton St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harris Scherr

6 DATE OF BIRTH (month, day, and year) Abt June 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Manuel = Not known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Henry Lehert
(Address) 109 N Poppleton St

15 Filed ..... 19.... NOV 26 1922 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19th, 1922, to Nov 25, 1922, that I last saw h.e. alive on Nov 25, 1922, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J. Murray M. D.

Nov 25 1922 (Address) 510 N. Bruce Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Shalom	11-26 1922
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69482

CERTIFICATE OF DEATH.

45 D69482

REGISTERED NO.

1-PLACE OF DEATH Bay View Hosp.

CITY OF BALTIMORE: (No. Eastern Ave. St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Jefferson

(a) RESIDENCE NO. ~~711 School~~ 1117 Shirks alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of widower

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE Years 76 | Months — | Days — | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Richard Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ann Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Municipal Hosp. Records

15 Filed NOV 23 1922, 19.... ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-24 1922

17 I HEREBY CERTIFY, That I attended deceased from 5-23, 1922, to 11-24, 1922, that I last saw him alive on 11-24, 1922, and that death occurred, on the date stated above, at 11. A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) J. Richardson Joyce M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. | DATE OF BURIAL Nov. 27 1922

20 UNDERTAKER Chris. H. Johnson | ADDRESS 16 N. Carolin St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

Dority

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69483

CERTIFICATE OF DEATH.

D69483

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4027 Dalrymple Avenue (WARD) 25

2-FULL NAME Zelma J. Dority

(a) RESIDENCE. NO. 4027 Dalrymple Avenue WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15th 1880

7 AGE — Years: 42 Months: 8 Days: 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Milliner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 6

9 BIRTHPLACE (city or town) (State or country) Unionville Frederick Co. Md

PARENTS

10 NAME OF FATHER Harry W. Dority

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unionville Frederick Co. Md

12 MAIDEN NAME OF MOTHER Sarah C. Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unionville Frederick Co. Md

14 Informant Mrs. Helen M. Dodd (Address) 4027 Dalrymple Avenue

15 Filed NOV 28 1922 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25th 1922

17 I HEREBY CERTIFY, That I attended deceased from August 23rd, 1922, to Nov 25th, 1922, that I last saw h[illegible] alive on Nov 25th, 1922, and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. 10 mos. — ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Urinalysis.

(Signed) William J. Sullivan, M. D.

Nov 25, 1922 (Address) 1701 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Unionville Frederick Co. Md

DATE OF BURIAL: NOV 27 1922 19

20 UNDERTAKER: Geo W. Little

ADDRESS: 2700 Edmondson Ave

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69484 D69484

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 Wilkens Ave ST.) 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Ellis

(a) RESIDENCE NO. 1912 Wilkens Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced? (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Ellis

6 DATE OF BIRTH (month, day, and year): Jan 29-1852

7 AGE: Years 70 | Months 9 | Days 29 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Benj Schickells

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Frank E. Ellis 1912 Wilkens

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1922, to Nov 25, 1922, that I last saw her alive on Nov 24, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): Diabetes mellitus

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & phys. exam.

(Signed) Geo M Dean, M. D.

11/25, 1922 (Address) 20 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 28 192

20 UNDERTAKER: W. C. Richardson — ADDRESS: North Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69485

CERTIFICATE OF DEATH.

100-001

D69485

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 268 Robert St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Emanuel Stamm

(a) RESIDENCE NO. 268 Robert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Stamm

6 DATE OF BIRTH (month, day, and year) July 15 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	78	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm H Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Ann Mulvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Massachusetts

14 Informant Mrs. V. Crouch (Address) 1938 Linden Ave

15 Filed ....., 19 ..... Registrar

NOV 25 1922 ROBERT R. KRAUSER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20th, 1922, to Nov. 25, 1922, that I last saw h[illegible] alive on Nov. 24th, 1922, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Chr Bronchitis

(duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical diagnosis

(Signed) J W Keown M. D.

Nov 25 1922 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cemetery — DATE OF BURIAL 11/27 1922

20 UNDERTAKER H. Leonhardt Sons — ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69486

CERTIFICATE OF DEATH.

44

D69486

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3300 WINDSOR AVE ST., 15 WARD)

2-FULL NAME MINNIE CHURCH SIMMONS BURNHAM

(a) RESIDENCE NO. 3300 Windsor ave ST., 15 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	MARRIED

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of ALFRED H. BURNHAM

6 DATE OF BIRTH (month, day, and year) 20 Oct 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HOUSEKEEPER

(b) General nature of industry, business, or establishment in which employed (or employer) HOME

(c) Name of employer —

9 BIRTHPLACE (city or town) LITTLE COMPTON (State or country) RHODE ISLAND

PARENTS

10 NAME OF FATHER VALENTINE SIMMONS

11 BIRTHPLACE OF FATHER (city or town) Little Compton (State or country) R. I.

12 MAIDEN NAME OF MOTHER Abby Taylor

13 BIRTHPLACE OF MOTHER (city or town) Little Compton (State or country) R. I.

14 Informant Alfred H. Burnham

(Address) 3300 Windsor Ave

15 Filed NOV 26 1922, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 24 1922 10 a.m.

17 I HEREBY CERTIFY, That I attended deceased from Oct-16-, 1922, to Nov-24, 1922, that I last saw h[illegible] alive on Nov-23, 1922, and that death occurred, on the date stated above, at 10-15 a.m.

The CAUSE OF DEATH* was as follows: Carcinoma Pylorus with general metastases.

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) General Asthenia.

(duration) — yrs. — 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of U.P.D. for Dx

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Operation

(Signed) Wesley Bell M. D.

(Address) 2202 Fenwick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Nov 27 1922

20 UNDERTAKER Geo. J. Ireland for Hartzler — ADDRESS [illegible]

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Blks.

D69487

D69487 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69487

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 Main ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Williams

(a) RESIDENCE NO: 212 Main ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER [illegible] Maynard

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER [illegible] Hayes

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Interment Nov 26 1922

(Address) 212 Main

15 Filed NOV 26 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 11th, 1922 to Nov 23rd [illegible]

that I last saw him alive on Nov 23rd 1922

and that death occurred, on the date stated above, at 11 45 A m.

The CAUSE OF DEATH* was as follows:

Mental Condition

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Duncan M. D.

11/25 1922 (Address) 1701 N Futon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Nov 27 1922

20 UNDERTAKER W. J. Gudwood & Son

ADDRESS Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

✓ D69488

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69488

CERTIFICATE OF DEATH.

179 D69488

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Darley Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christopher Hammann.

(a) RESIDENCE No. 1406 Darley Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bernardine Hammann

6 DATE OF BIRTH (month, day, and year): March 14th 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 80

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: William Schneider

(Address): 1406 Darley Ave

15 Filed NOV 26 1922 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 19 22, to Nov 24, 19 22,

that I last saw h[e] alive on Nov 23, 19 ...,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows: Colitis

Acute Entero Colitis

(Duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chr Interstit Nephritis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Only Physical Exam.

(Signed) Wm K. Geraghty M. D.

11/26, 19 22 (Address) 202 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Nov 27 1922

20 UNDERTAKER: Frank A. Fink

ADDRESS: 910 N Gay

Spec.—1-10-21 M&T 1500 Bks.

D69489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69489

CERTIFICATE OF DEATH.

47

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME Mrs. Helen Cohn

(a) RESIDENCE NO. 2309 Roslyn Ave - Walbrook ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Cohn

6 DATE OF BIRTH (month, day, and year): Dec. 21 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	51	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Thomas Woodhall

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Emma A. Kuhns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Charles Cohn

(Address) 2309 Roslyn Ave

15 Filed ..... 19 .....

NOV 26 1922 ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1922, to Nov 24, 1922

that I last saw her alive on Nov 24, 1922,

and that death occurred, on the date stated above, at 5.00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast, right

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism few moments

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Nov 18 '22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Keith B. Rice, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem.

DATE OF BURIAL: 11/27 19 22

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69490

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D69490

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin corner Loop ST., 27 WARD)

2-FULL NAME Anna K Kaltenbach

(a) RESIDENCE NO. 119 Linden Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Vernon Kaltenbach

6 DATE OF BIRTH (month, day, and year): Dec 10 1878

7 AGE — Years: 43 — Months: 11 — Days: 20 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED: Housewife

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Aug Goeffner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma Pofel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Vernon Kaltenbach
(Address): 119 Linden Ave

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER, Registrar
NOV 20 1922
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1922, to Nov 20, 1922, that I last saw h alive on Nov 24, 1922, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 6 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary): Hypostatic Congestion

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Neele Thomas M. D.

(Address) 1228 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Nov 29 1922

20 UNDERTAKER: John Uelrich

ADDRESS: 2008 Oliver

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69491

REGISTERED NO. 101-001 D69491

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 732 E. Hamilton ST.: 11 WARD)

2-FULL NAME. Whitney Russell

(a) RESIDENCE. NO. 732 E. Hamilton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy M. Beckham

6 DATE OF BIRTH (month, day and year) May 20 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer): 109
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston Mass

PARENTS
10 NAME OF FATHER Walter A. Russell
11 BIRTHPLACE OF FATHER (city or town) (State or country) New Hampshire
12 MAIDEN NAME OF MOTHER Mabel Whitney
13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Hampshire

14 Informant Mrs Dorothy Russell
(Address) 20 Hamilton Ter

15 Filed NOV 2 0 1922 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1922, to Nov 24, 1922, that I last saw h[illegible] alive on Nov 24, 1922, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Samuel Hyman, M. D.

Nov 24 1922 (Address) 27 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Nov 26 1922

20 UNDERTAKER John Elliott — ADDRESS 2008 Aliceanna

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1922-38 D69492

CERTIFICATE OF DEATH.

88 D69492

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.

CITY OF BALTIMORE: (No.) ST., (WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis De Filippo

(a) RESIDENCE No. 611 N. Rose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 12-1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Anthony De Filippo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosie Lanciaperna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Johns Hopkins Hospital (Address) Record

15 Filed NOV 26 1922, 19 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24th 19 22

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 19 22, to Nov 24, 19 22, that I last saw him alive on Nov. 23, 19 22, and that death occurred, on the date stated above, at 2.40 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Nov 27 1922

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on tho first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) tho kind of work and also (*b*) tho nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chorea – 3 mos.

Spec.—1-10-21—M&T—1500 Bks.

Laux

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69493

CERTIFICATE OF DEATH.

90 D69493

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2723 W. Lafayette Ave 16 WARD)

2-FULL NAME Ida Louise Laux

(a) RESIDENCE No 2723 W Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND, of (or) WIFE of Frederick Laux

6 DATE OF BIRTH (month, day, and year) Aug. 12-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Aug. 12	48	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER Robert C. Boice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wilkes Barre Pa

12 MAIDEN NAME OF MOTHER Mary V. Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Philadelphia Pa

14 Informant Mrs. A. C. Franklin (Address) 2723 W. Lafayette

15 Filed NOV 23 1922 ROBERT R. KRAUTER, Registrar Burial Permit Section

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1922.

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1921, to Nov 24, 1922, that I last saw her alive on Nov 24, 1922, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion

of Heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam

(Signed) John A. Chatard, M. D.

Nov 26 1922 (Address) 1219 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phila Pa.

DATE OF BURIAL 11/27 1922

20 UNDERTAKER Wm. M. Crawthop

ADDRESS 2839 Ray

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69494

CERTIFICATE OF DEATH.

D69494

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 N. Howard ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth J. Foudriat

(a) RESIDENCE NO. 722 N. Howard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 14, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Pierre Foudriat

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Marie Josephine Roge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Emelie C. Foudriat

(Address) 722 N. Howard Street

15 Filed NOV 26 1922, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1922.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1922, to Nov. 25, 1922, that I last saw h[illegible] alive on Nov. 24, 1922, and that death occurred, on the date stated above, at 12° A. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis.

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis —

(duration) 7 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. symptoms

(Signed) Carsten H. Robinson M. D.

19 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 11/ 25 19 22

20 UNDERTAKER: Henry W. Meara & Son

ADDRESS: W. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69495

CERTIFICATE OF DEATH.

100-001 D69495

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 514 S Bond ST., 3 WARD)

2-FULL NAME Recyslaus Czyzewski

(a) RESIDENCE NO. 514 S Bond ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 13 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanislaus Czyzewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Lena Jankowiak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Lena Czyzewski

(Address) 514 S Bond St

15 Filed NOV 28 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1922

17 I HEREBY CERTIFY, That I attended deceased from 11/24, 1922, to 11/25, 1922,

that I last saw h[illegible] alive on 11/25, 1922,

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Heart failure & cachexia

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Signs & Symptoms

(Signed) [illegible] M. D.

1922 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Nov 26 1922

20 UNDERTAKER John M Weber — ADDRESS 1803 Bank

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. Tho contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69496

D69496

CERTIFICATE OF DEATH. 145-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 N. Streeper St., 6 WARD)

2-FULL NAME Mary E. Henderson

(a) RESIDENCE NO. 140 N. Streeper ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARNING RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ironia J. Henderson

6 DATE OF BIRTH (month, day, and year): Aug. 12 - 1880

7 AGE: Years 42 Months 3 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John F. Neary

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Mary A. Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Ironia J. Henderson

(Address) 140 N. Streeper St

15 Filed NOV 25 1922, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1922, to Nov 24, 1922,

that I last saw h alive on Nov, 19,

and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia & Chronic Arthritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Child Birth,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. O Brown M.D.

Nov 25 1922 (Address) 2600 E. Balto, Co.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 11/27/1922

20 UNDERTAKER: L. A. Inolan

ADDRESS 3000 E. Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69497

99-001

D69497

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5126 Reisterstown Road ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kessler

(a) RESIDENCE. No. 5126 Reisterstown Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy A. Kessler

6 DATE OF BIRTH (month, day, and year) Dec. 2 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Pickeling

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Ella Kessler Stonebraker (Address) 5126 Reisterstown Road

15 Filed NOV 26 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 19th, 1922, to Nov. 24th, 1922, that I last saw him alive on Nov. 23rd, 1922, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follnws:

Old age

Bronchitis (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chas. H. Bubert, M. D.

, 19 (Address) 1100 W. Laf. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: Nov 27 1922

20 UNDERTAKER: Chas. G. Black ADDRESS 742 W. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69498 89 D69498

REGISTERED NO.

D69498

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3785 Culver ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry A. Spittel

(a) RESIDENCE. No 3785 Culver ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 V yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Annie K. Spittel

6 DATE OF BIRTH (month, day, and year) March 1-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Pool Engineer Co. Balto. City

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry O. Spittel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Frederieke Dane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

11 Informant (Address): Annie K. Spittel 3785 Culver St.

NOV 26 1922

ROBERT R. KIRWAN Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1922, to Nov 24, 1922, that I last saw h[illegible] alive on Nov 24, 1922, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris, Coronary Arterio Sclerosis.

(duration) yrs. mos. 5 days

CONTRIBUTORY (Secondary) General Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard W Jane, M. D

Nov. 19 4 (Address) 722 Augusta Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park cemetery — DATE OF BURIAL: Nov 27 1922

20 UNDERTAKER: Chas. D. Black — ADDRESS: 742 W. Northave

Spec.—6-9-19—H. P. Co.—1000 Bks.

69499 D69499

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 69499

CERTIFICATE OF DEATH.

161-201 D69499

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 Glyndon ST., 21 WARD)

2-FULL NAME Infant of Mr & Mrs A. P. Griffin

(a) RESIDENCE. NO. 1262 Glyndon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 25 /22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Anthony P. Griffin

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Naomi Turner

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Mrs A. P. Griffin (Address) 1232 Glyndon ave

15 Filed NOV 27 1922 16 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1922, to Nov 25, 1922, that I last saw h in alive on Nov 25, 1922, and that death occurred, on the date stated above, at 1-15 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Pneumonia Atelectasis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ephemeritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. Ch Campbell, M. D.

Nov 27, 19 22 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	11/27 19
20 UNDERTAKER	ADDRESS
Bernard A Funk	1756 Washington Blvd

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr Shuman - 905 N. Charles

Spec.—1-10-21—M&T—1500 Bks.

69500

HEALTH DEPARTMENT—CITY OF BALTIMORE

69500 D69500

CERTIFICATE OF DEATH.

99-001 D69500

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1811 N. Smallwood ST., 15 WARD)

2-FULL NAME Merritt Dionneal

(a) RESIDENCE NO. 1811 N Smallwood ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Louise Dionneal

6 DATE OF BIRTH (month, day, and year) June 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

10 NAME OF FATHER Charles Morrise Dionneal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Louise Kinner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Maurice Dionneal Cabinet-Ebenezer Apts

15 Filed NOV 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 20th, 1919, to Nov. 25th, 1922, that I last saw him alive on November 25th, 1922, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

ARTERIO-SCLEROSIS

(duration) 3 yrs. 5 mos — ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas L. Shearer, M. D.

Nov 26 1922 (Address) 905 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	11/28 1922
20 UNDERTAKER Wm Cook	ADDRESS 0822 N Gay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 69501

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 69501

CERTIFICATE OF DEATH.

90

D 69501

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3815 Clifton ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Lewinsohn

(Residence in Baltimore: No. 3815 Clifton ave St.; 50 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED,~~ ~~WIDOWED,~~ ~~OR DIVORCED,~~ (Write the word.) Widowed

6-DATE OF BIRTH, June (Month) 5 (Day) 1856 (Year)

7-AGE, 65 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or estsblishment in which employed (or employer): " "

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Mendel Phillips

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Emma Phillips

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Walters

(Address) 3815 Clifton ave.

15-

Filed NOV 27 1922 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 25 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1922, to Nov 25 1922, that I saw her alive on Nov 25 1922, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

..... (Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. O. Lloyd M. D.

Nov 25, 1922 (Address) 3132 Eutaw pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Har Sinai Cem

DATE OF BURIAL, 11/28, 1922

20-UNDERTAKER J. ARNETS & CO. FUNERAL DIRECTORS AND EMBALMERS 1511 MADISON AVENUE.

ADDRESS

D69502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69502

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1385 N. Gilmor St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sister M. Rita Leberty

(Residence in Baltimore: No. 1385 N. Gilmor St. St.; yrs. 54 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1868 (Year)

7-AGE: 54 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sister of Charity
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: John Leberty

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Ann Kenney

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Joseph

(Address) 1385 N Baltimore

15- Filed NOV 27 1922 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 25, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, Autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Central Pneumonia

(Duration) 11 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) and Cirrhosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D. (Coroner)

Nov. 24 1922 (Address) 2802 E Lombard St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt St Agnes Mt Wash DATE OF BURIAL: Nov. 27 1922

20-UNDERTAKER: Maslin Fraley & Son ADDRESS 1827 W Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69503

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

159-003 695-03 D69503

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3206 Harford ave ST. 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Erdman

(Residence in Baltimore: No. Same St.: yrs. mos. 3 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX M

4-COLOR OR RACE W

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Single

6-DATE OF BIRTH Nov 23, 1922
(Month) (Day) (Year)

7-AGE ..... yrs. ..... mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country) Balt

PARENTS

10-NAME OF FATHER Clarence Erdman

11-BIRTHPLACE OF FATHER (State or country) Balt

12-MAIDEN NAME OF MOTHER Mary Keller

13-BIRTHPLACE OF MOTHER (State or country) Balt

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Erdman

(Address) 3206 Harford ave

15-NOV 27 1922 ROBERT R. KRAUTER, Burial Permit Clerk.
Filed ..... 191 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Nov 26, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23, 1922 to Nov 26 1922, that I saw h[illegible] alive on Nov 25, 1922, and that death occurred, on the date stated above, at 6 Am.

The CAUSE OF DEATH* was as follows:

Congenital Portal obstruction

(Duration) ..... yrs. ..... mos. 3 ds

Contributory (SECONDARY) Hemorrhage of Bowels 3 hrs

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo J Schilling MD

Nov 26, 1922 (Address) 1167 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Nov 27th, 1922

20-UNDERTAKER George Schilling & Sons

ADDRESS 1167 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69504 D69504

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2136 Druid Hill Ave St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary McGibbs

(Residence in Baltimore: No. 2136 Druid Hill Ave St.; 71 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June — 1851 (Month) (Day) (Year)

7-AGE, 71 yrs. 5 — mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Own

9-BIRTHPLACE, (State or Country), Balto city

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Seprade

(Address) 2136 Druid Hill Ave

15- NOV 27 1922 ROBERT R. KRAUTER, Registrar.

Filed....., 191..... Burial Permit.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 24, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1922, to Nov 24 1922,

that I saw h alive on Nov 21 1922,

and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Cor. Pulmonale (Primary)

Myocarditis

Arteriosclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY Hepatitis (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. H. Welch M. D.

Nov 25, 1922 (Address) 1211 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Nov. 27 1922

20-UNDERTAKER John H. Frodsham

ADDRESS 142 W Hill St

Barney Mendleson

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

64506

90

D69505

CERTIFICATE OF DEATH.

D69505

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Barney. Mendleson

CITY OF BALTIMORE: (No.) 1133 E. Lombard ST.; 3 WARD)

2-FULL NAME Barney Mendelsohn

(a) RESIDENCE. NO. 1133 E. Lombard ST., 3 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Mendleson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant A. L. Rotstein

(Address) 1707 Eutaw st

15 Filed ..... 19.. Registrar

NOV 27 1922 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-26-1922

17 I HEREBY CERTIFY, That I attended deceased from 11-24-, 1922, to 11-26-, 1922, that I last saw h im alive on 11-26-, 1922, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Senility, mitral and aortic insufficiency.

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? neg.

Did an operation precede death? no Date of —

Was there an autopsy? none

What test confirmed diagnosis? Physical Exam.

(Signed) Solomon Cohen M. D.

11/26 1922 (Address) 116 McGeath St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern ave

DATE OF BURIAL NOV 27 1922

ADDRESS 1127 E Baltimore

20 UNDERTAKER Max Lennon

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69506

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69506

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James C. O'Rourke

(Residence in Baltimore: No. 343 W 21st St St.; yrs., mos., ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: January (Month) 28 (Day) 1879 (Year)

7-AGE: 42 yrs. 9 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Iron Worker
(b) General nature of Industry, business, or establishment in which employed (or employer): Structural

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: James O'Rourke

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mary Powers

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. O'Rourke

(Address) 343 W 21st St.

15-

Filed ..... 192.... .....

Registrar.

NOV 27 1922

ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 23 (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to the death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushes Skull - Broken neck

Fell from ladder on smoke stack

Pima R.R. Round House Curtis Bay

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Intoxication & Exposure

Nov 23 1922 (Duration) .....yrs. .....mos. .....ds.

(Signed) J. S. H. Culley M. D.

(Coroner.)

11-25 192.2 (Address) 508 E. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Catholic Cem

DATE OF BURIAL: 11/27 19....

20-UNDERTAKER, J. Lakey

ADDRESS 1918 Eastern Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

D69507

HEALTH DEPARTMENT—CITY (Borey) OF BALTIMORE

D69507

CERTIFICATE OF DEATH.

188-601

Registered No. D 69507

1-PLACE OF DEATH B&O R.R. Laurel on

City of BALTIMORE: (No. Ridgely St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Bory.

(Residence in Baltimore: No. 718 Stockholm St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Married

6-DATE OF BIRTH. Jan. 19th 1893
(Month) (Day) (Year)

7-AGE. 29 yrs. 10 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Eastern Rolling Mills

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER, Frank C. Bory.

11-BIRTHPLACE OF FATHER, (State or Country) Balto, Md

12-MAIDEN NAME OF MOTHER, Lena Bergman

13-BIRTHPLACE OF MOTHER, (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary S. Bory.

(Address) 718 Stockholm —

15-

Filed ..... 192.... Registrar.

ROBERT R. KRAUTER,
NOV 27 1922
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Crushed Skull cut - Wound abdomen Distinguished Legs Broken R.R. accident (Duration) yrs. mos. ds. Sudden

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) James McTernan M. D.
(Coroner.)

Nov 26 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Cross A.A.Co	11-27 1922

20-UNDERTAKER.	ADDRESS
James Tigman	1000 S Paca St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69508 **D69508**

CERTIFICATE OF DEATH.

90

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2317-19 Penna ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie adler

(Residence in Baltimore: No. 2317-19 Penna ave St.; 20 yrs.. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.) Widowed

6-DATE OF BIRTH, Unknown (Month) (Day), 1831 (Year)

7-AGE, 91 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Balto st

15-

NOV 27 1922

Filed....., 191.....

ROBERT H. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1922 to Nov 26 1922

that I saw her alive on Nov 25 1922

and that death occurred, on the date stated above, at 10 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Dont Know (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D A Lloyd M. D.

Nov 26, 1922 (Address) 2232 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Mach Rood

DATE OF BURIAL, 11-28, 1922

20-UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

HEALTH DEPARTMENT—CITY OF BALTIMORE D69509

D69509

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. W. O. I, St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Ruth Stalipher Widdowson

(Residence in Baltimore: No. 1830 Madison ave St. Hrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	married

6-DATE OF BIRTH. January 31 1878
(Month) (Day) (Year)

7-AGE. 44 yrs. 9 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Hancock, Md.

PARENTS.

10-NAME OF FATHER. John Stalipher

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Annie E Krishner

13-BIRTHPLACE OF MOTHER, (State or Country). Cearsburg Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. K. Widdowson

(Address) 1830 Madison Ave

15-

Filed NOV 27 1922 192.... ROBT. R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 23, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq- (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ....yrs. ....mos. 1 ....ds.

CONTRIBUTORY (Secondary) arterial hypertension

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Nov. 24 192.. (Address) 2805 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Druid Ridge Cem DATE OF BURIAL. Nov 27 1922

20-UNDERTAKER. Ashland Co ADDRESS 1125 N Eutaw St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69510

CERTIFICATE OF DEATH.

100-001 D69510

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1927 W. Lafayette ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet M. Glynn

(a) RESIDENCE. No. 1927 W. Lafayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced (or) WIFE of Lieut John J. Glynn

6 DATE OF BIRTH (month, day, and year) March 27 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Magill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) do not know

14 Informant Mr. Alfred J. Harrall

(Address)

15 Filed NOV 27 1922 19 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19 22, to Nov 25 19 22,

that I last saw her alive on Nov 25 19 22,

and that death occurred, on the date stated above, at 6:40 A m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. F. Lemmert, M. D.

Nov. 27 1922 (Address) 3 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Nov 28 1922

20 UNDERTAKER: Emerson Jenkins & Sons Co — ADDRESS: McCulloh Orchard

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69511

D69511

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Municipal Hospital ST., 26 WARD)

2-FULL NAME Frank Rielly or Wiley

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ...min.
	?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown N. Y. (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... Registrar

NOV 27 1922 ROGER R. KRAUTER, Registrar Baltimore County

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 19 22

17 I HEREBY CERTIFY, That I attended deceased from November 18, 19 22, to November 21 19 22.

that I last saw h.. alive on November 21, 19 22.

and that death occurred, on the date stated above, at 10:00 A M.

The CAUSE OF DEATH* was as follows:

Chronic Syphilis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy? Yes

What test confirmed diagnosis? W.P.W.; Path; Micro

(Signed) Clyde Marvel, M. D.

11/23/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER Commissioner Health.

DATE OF BURIAL 19

ADDRESS NOV 25 1922

Per. Wm. E. WEGDALL.

381

19602.

Spec.—1-10-21—M&T—1500 Blks.

D. 69512

15 7 81

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 69512

161-001

D69512

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Tate.

(a) RESIDENCE No. 1211 E. Fillmore St. City ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos., ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1922.

7 AGE: Years — Months — Days 24. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER Harry Tate.

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Mary Grant.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Maryland.

14 Informant (Address) Johns Hopkins Hospital Balto

15 Filed NOV 27 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1922, to Nov 21, 1922, that I last saw him alive on Nov 21, 1922, and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. 6 wks.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) H. H. Mesch, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL NOV 27 1922, 19

20 UNDERTAKER Commissioner Health.

ADDRESS

Per. Wm. B. WOSBAU

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

38

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69513 HEALTH DEPARTMENT—CITY OF BALTIMORE **D69513**

CERTIFICATE OF DEATH.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2020 Etting ST.: 14 WARD) 31

REGISTERED NO. D69513

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur E West

(a) RESIDENCE. NO. 2020 Etting ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-8-1880

7 AGE	42 Years	2 Months	18 Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joshua E West

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Bias

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Mrs.) Lillie West (Address) 2020 Etting St

15 Filed Nov 28 1922 Registrar Robert R. Krauter

NOV 28 1922 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1922

17 I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Nov 26 1922

that I last saw him alive on Nov 26 1922

and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency; Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Cannot say

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Chas Short, M. D.

11/26 1922 (Address) 1812 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	11-28 1922

20 UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

D69514

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69514

117

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 Jasper, ST.: 17 WARD)

2-FULL NAME Richard Sydings

(a) RESIDENCE. No. 633 Jasper ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Valley

(b) General nature of industry, business, or establishment in which employed (or employer) Valley

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Enick Sidings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Sophia Sidings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

11 Informant Rosie Sidings

(Address) 633 Jasper St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 24 1922

17. I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1922, to Nov. 24, 1922

that I last saw him alive on Nov. 24, 1922

and that death occurred, on the date stated above, at 11.30 p.m.

The CAUSE OF DEATH* was as follows:

Rupture of Abscess of Appendix.

Surgical Injection

(duration) yrs. mos. ds.

—

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) [illegible] M. D.

25, 1922 Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	November 27 1922
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69315
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Irlin
1552

D69315
Registered No. .....

City of BALTIMORE: (No. John Hopkins Hosp. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... John T. Irlin.....

(Residence in Baltimore: No. 1609 E. Monument St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	Black	S

6-DATE OF BIRTH. ..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
17 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)..... School Boy

9-BIRTHPLACE. (State or Country). Balto

PARENTS.

10-NAME OF FATHER. John T. Irlin

11-BIRTHPLACE OF FATHER. (State or Country). Va

12-MAIDEN NAME OF MOTHER. Mary Owens

13-BIRTHPLACE OF MOTHER. (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Owens Irlin

(Address) 1609 E. Monument

15- Filed NOV 27 1922 192 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Meningitis

Pneumococcus & probably Streptococcus

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fracture of Sphenoid Sinus allergy to Horse Infection

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Bruce Gallup M. D.
(Coroner.)

11-26 1922 (Address) 518 E. Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Asbury Cemetery	Novemb 28. 1922
20-UNDERTAKER.	ADDRESS
Mrs Robert A Elliott	1725 Ashland Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69516

CERTIFICATE OF DEATH.

D69516

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Hollander.

(a) RESIDENCE. NO. 1921 Oakhill ST. Ave WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Deborah Hollander

6 DATE OF BIRTH (month, day, and year) Oct. 21, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~60~~	59	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Button Hole

(b) General nature of industry, business, or establishment in which employed (or employer) Mnfg.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Abraham A. Hollander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mollye Headler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) Mr. A. Hofberger 1921 Oakhill Ave.

15 Filed NOV 27 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1922

17 I HEREBY CERTIFY, That I attended deceased from August 26, 1922, to November 26, 1922, that I last saw him alive on November 26, 1922, and that death occurred, on the date stated above, at 5-8 m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. ds.

(1) Chronic Cardiac Valvular disease Aortic Insuf.

CONTRIBUTORY (Secondary) (2) Chr. Myocarditis, Cardiac Insuf. Sen. Art. Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Moses Gelman, M. D.

, 19 (Address) Hebrew Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem.	11/29/ 1922
20 UNDERTAKER David Sondheim	ADDRESS 1118 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69517

CERTIFICATE OF DEATH.

74-001

D69517

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2003 Eutaw Place (WARD) 44

2-FULL NAME Edwin Reizenstein

(a) RESIDENCE. No. 2003 Eutaw Place. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mnfg. Agent.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila. Pa.

PARENTS

10 NAME OF FATHER Herman Reizenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Wornitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. A. Reizenstein 2003 Eutaw Place

15 Filed NOV 27 1922 (19) ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/26/22.

17 I HEREBY CERTIFY, That I attended deceased from 11-25, 1922, to 11-26, 1922, that I last saw h[illegible] alive on 11-26, 1922, and that death occurred, on the date stated above, at 4:15 a. m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular disease
(Uremia - Sclerosis)

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

10 hours (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? [illegible] Wa.R. 260

(Signed) [illegible] G. Barrett, M. D.

. 19 (Address) 2000 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Har Sinai Cem.	11/28/ 1922
20 UNDERTAKER	ADDRESS
David Sondheim	118-20 W. Mt. Royal Ave.

Spec.—1-10-21—M&T—1500 Bks.

Forsythe.

D69518

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

D69518

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE, (No. 1222 E. Lafayette Ave ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME James H. Childs

(a) RESIDENCE NO. 1222 E Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret C

6 DATE OF BIRTH (month, day, and year): March 24 1857

7 AGE: Years 66 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Enfield McChilds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Caroline Hordes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Margaret Childs (Address): 1222 E Lafayette

15 Filed . . 19 NOV 27 1922 Registrar

ROBERT R. HUNTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1922, to Nov. 26, 1922, that I last saw h/m alive on Nov. 25, 1922, and that death occurred, on the date stated above, at 2.50 p. m.

The CAUSE OF DEATH* was as follows:

Endocarditis.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arthritis probably from an infected tooth (duration) yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

. 19 (Address) 422 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether accidental, Suicidal, or Homicidal. (See reverse side for additional space

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov. 29 1922

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69519

CERTIFICATE OF DEATH.

D69519

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Liberty & Park Heights St. (WARD)

2-FULL NAME Louis Blanquette

(Residence in Baltimore No. Evergreen Apt, Palmer & Evergreen Place St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 10, 1890
(Month) (Day) (Year)

7-AGE, 32 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Drug Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). Cushinger Store

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER Emil Blanquette

11-BIRTHPLACE OF FATHER (State or Country) unknown

12-MAIDEN NAME OF MOTHER Louis T Brown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Oestreicher

(Address) 1570 Carswell St. Md

15- NOV 27 1922 ROBERT R. KRAUTER, Registrar.
Filed ....., 191.. Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 25, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypertrophosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Morrissey M. D.
(Coroner.)

Nov 28, 1922 (Address) 7632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Nov 28, 1922

20-UNDERTAKER Williams

ADDRESS 502 E North Ave

Dr Morrissey Roland Ave

Kemp ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69520

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69520

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green Sts ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Kemp

(a) RESIDENCE. NO. 833 Calvert Road ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Martin Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophie Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Ralph W. Martin 1806 Riggs Av

15 Filed . 19 Registrar

NOV 27 1922 ROBERT R. KRAMER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/26 1922

17 I HEREBY CERTIFY, That I attended deceased from 11/22 . 19 26. to 11/26 . 19 22

that I last saw her alive on 11/26 . 19 22.

and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) unknown

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Thos Ferguson . M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park C. -	Nov 28 19 22
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Monument

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Feuerstein ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69521

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 N. Lucerne ST.; 8 WARD)

2-FULL NAME Jno Hy. Feuerstein

(a) RESIDENCE. No. 1427 N. Lucerne ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

129

D69521

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 18. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Depot

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Feuerstein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Hendricks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Lena Feuerstein
(Address) 1427 N. Lucerne Ave

15 Filed NOV 27 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 25 19 22

17 I HEREBY CERTIFY, That I attended deceased from 1.4.22, 19..., to 11.25.22, 19...,
that I last saw him alive on 11.25.22, 19...,
and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1242 Riverside Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chemical & Micro of urine

(Signed) Philip S. Lauler, M. D.

11.27.22 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	11/28 19 22
20 UNDERTAKER Wm. Cook	ADDRESS 502 E. Natty

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69522

CERTIFICATE OF DEATH.

100-001

D69522

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 Colvin ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicola Lanzo

(Residence in Baltimore: No. 414 Colvin St ST.; 25 yrs. ..... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, October (Month) 15 (Day), 1873 (Year)

7-AGE, 49 yrs. 1 mos. 11 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Moise Lanzo

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Angela Cimino

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Teresa Lanzo

(Address) 414 Colvin St.

15-

Filed ..... 191.....

NOV 29 1922

ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 26th (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21st 1922, to Nov 26th 1922

that I saw h[illegible] alive on Nov 25th 1922

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Cron bronchitis

..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Chas. Testa M. D.

....., 191... (Address) 210 Pearl St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem

DATE OF BURIAL, Nov. 27, 1922

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Hanford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69523

CERTIFICATE OF DEATH (Male) 161-001

D69523

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1405 Mc Culloh St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Baby Heald

(Residence in Baltimore: No. 1405 Mc Culloh St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem'l

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If the word): Single

6 DATE OF BIRTH: 11 (Month) 25 (Day), 1922 (Year)

7 AGE: yrs. mos. 2 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: John Day

11 BIRTHPLACE OF FATHER (State or country): N.Y.

12 MAIDEN NAME OF MOTHER: Mary Heald

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amelia Gibson

(Address) 1405 Mc Culloh St

15 Filed NOV 27 1922, 191 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 11 (Month) 27 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1922, to Nov 27 1922, that I saw her alive on Nov 26, 1922, and that death occurred, on the date stated above, at 1 a m

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) yrs. mos. 2 ds.

Contributory (SECONDARY) Premature birth

(Duration) yrs. mos. ds.

(Signed) I. C. Hamburger M. D.

Nov 27, 1922 (Address) 1202 Druid Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Nov. 28th, 1922

20 UNDERTAKER: Jno M. Johnson — ADDRESS: 1234 Ething St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69524

CERTIFICATE OF DEATH.

REGISTERED No. D69524

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH 4112 Greenway Gulford (No. of House) (Name of Street) (Ward)

CITY OF BALTIMORE

2-FULL NAME Mary Saddington

(Residence in Baltimore: No. 4112 Greenway Gulford St.; yrs., (2 mos.) ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, (Month) Unknown, (Day) 1 (Year)

7-AGE. about 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. H. Whitridge

(Address) 4112 Greenway Gulf

15-

Filed NOV 27 1922 (1922) ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 26, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest found that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Thomas M. D. (Coroner.)

Nov 27 1922 (Address) 3632 Roland Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Evergreen Cem. Baltimore City

DATE OF BURIAL, Nov. 27 1922

20-UNDERTAKER Henry A. Jenkins & Son

ADDRESS 1216 Eutaw St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69525

CERTIFICATE OF DEATH.

8 129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D69525

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 N. Broadway ST., 8 WARD)

2-FULL NAME Mrs Sophia Greber.

(a) RESIDENCE NO. 1317 N. Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Conrad Greber.

6 DATE OF BIRTH (month, day, and year): May 25/1835.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Invalid.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: William Lotz.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Philapenia Pötts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs Wiskemann 224 n. calhoun st

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

NOV 27 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 25-H 1922

17

I HEREBY CERTIFY, That I attended ~~deceased~~ from Nov. 23-22, 19 22, to Nov. 25-H, 19 22, that I last saw her alive on Nov. 25-H, 19 22, and that death occurred, on the date stated above, at 6:45 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic interstitial Nephritis.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) ..... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of —

Was there an autopsy? none

What test confirmed diagnosis? yes

(Signed) Amelia Zimmerman, M. D.

, 19 (Address) 1805 W North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov 29 1922

20 UNDERTAKER: Henry Lutz — ADDRESS 1203 N. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

D69526 HEALTH DEPARTMENT—CITY OF BALTIMORE D69523

CERTIFICATE OF DEATH. 100-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 609 N. Paca St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Dallie Spencer

(Residence in Baltimore: No. 609 N. Paca St.; 13 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	colored	single

6-DATE OF BIRTH. about 1901 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
21 yrs. ..... mos. ..... ds.	..... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Scotland Co, Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. Wilson

(Address) 609 N. Paca St.

15- Filed NOV 27 1922 192.....

ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) ..... us histrungo

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Tennessay M. D. (Coroner)

Nov. 27 1922 (Address) 1802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Nov 27 1922

20-UNDERTAKER	ADDRESS
David Eaves	916 Pa Ave

Spec.—8-24-14—M. & T.—2000 Bks.

Sigai

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69527

CERTIFICATE OF DEATH.

129

D69527

REGISTERED NO. C.....

1-PLACE OF DEATH Hudson Heights

CITY OF BALTIMORE: (No. Colgate Rd. ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michal Sigai

(Residence in Baltimore: No. Colgate Rd. Balto. Co. St.; all 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) M.

6-DATE OF BIRTH, October, 1 (Month) (Day) (Year)

7-AGE, 90 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Sigai

(Address) Colgate Rd. Balto. Co.

15- NOV 27 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 5 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 1 1922, 191..., to November 5 1922, 191..., that I saw h.. alive on October 15 1922, 191..., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) .... yrs. .... mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (Duration) 2 yrs. .... mos. .... ds.

(Signed) D. D. Truman M. D.

11/7/22 1922 (Address) 2919 E. Balto.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Holy Cross. DATE OF BURIAL, Nov 24th, 1922

20-UNDERTAKER Wendel Zeppelsdorf ADDRESS 875 Lemmon St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D69528

HEALTH DEPARTMENT—CITY OF BALTIMORE D69528

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hyldebran Hospital ST.) 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Fells Fisher

(a) RESIDENCE. NO. 106 Hollendon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Eliz. Fells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Elizabeth Fisher

(Address) 106 Hollendon Ave

15 Filed ..... 19 .....

NOV 27 1922 ROBERT R. KRAUSER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 26, 1922, to Nov 26, 1922, that I last saw him alive on Nov 26, 1922, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, pharyngeal & laryngeal

(duration) - yrs. - mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bella Gowan, M. D.

11/26/22 (Address) Hyldebran Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Nov 29 1922

20 UNDERTAKER John T. Gowan & Son

Carl T. Gowan

ADDRESS 901 Hollins

Spec. 1-10-21 M&T 1500 Blks.

D69529

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69529

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2548 Woodbrook Ave (St.) (Ward) 15

2-FULL NAME William H. C. Gaines

(a) RESIDENCE NO. 2548 Woodbrook Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Gaines

6 DATE OF BIRTH (month, day, and year) Jan 28 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	64	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Grinder

(b) General nature of industry, business, or establishment in which employed (or employer) at Cotton works 6 8

(c) Name of employer Patapsco Co

9 BIRTHPLACE (city or town) (State or country) Craig Lane Md

PARENTS

10 NAME OF FATHER James E Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant ..... (Address) 2548 Woodbrook Ave

15 Filed ..... 19 ..... Registrar

NOV 27 1922 Robert F. Duffy Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to Nov 25, 1922.

that I last saw h.. alive on Nov 25, 1922.

and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Harford Co.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Wm H C Gaines M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL Nov 28 1922

20 UNDERTAKER Wm H Cook ADDRESS 603 N Calhoun St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Tuma) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69530

D69530

CERTIFICATE OF DEATH. 101-001

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 N Modiera ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Tuma

(Residence in Baltimore: No. 812 N Modiera St.; 52 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1870 (Year)

7-AGE, 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Notary
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Joseph Tuma

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine Tuma

(Address) 812 N Modiera

15-

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 24, 1922. (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Nov. 19 1922, to Nov 24 1922, that I saw h— alive on Nov 24 1922, and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Colon Carcinoma

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) yrs. mos. ds.

(Signed) Wm. H. Hanson M. D.

Nov 27, 1922 (Address) 806 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Rodeem	Nov 27 1922
20-UNDERTAKER	ADDRESS.
Funeral Direction	1411 Park

NOV 27 1922

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69531

D69531

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 S. Regester ST., W WARD)

2-FULL NAME Marie Majka

(a) RESIDENCE NO. 117 S. Regester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of Stanislaus. Majka

6 DATE OF BIRTH (month, day, and year) Sept 8-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Lidor Szczur.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Wikonya Idzik

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanislaw Majka
(Address) 117 S. Regester St

15 Filed ..... 19 ..... Registrar

NOV 2 1922

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/25 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1922, to Nov. 25, 1922

that I last saw h[illegible] alive on Nov 24, 1922

and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Nov 26, 1922 (Address) 806 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

Holy Rosary. Nov 28 1922

UNDERTAKER ADDRESS

William Fiel[illegible] 168 Eastern Ave

Spec.—1-10-21—M&T—1500 Bks.

D69532 D69532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hamilton and Hazelwood Aves ST., 1 WARD) Raspeburg

2-FULL NAME Mary Laura Lutz

(a) RESIDENCE NO. Hamilton and Hazelwood Aves ST., ... WARD Raspeburg

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9th 1921

7 AGE — Years: 1 — Months: 6 — Days: 17 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED — Infant

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER Frank P. Lutz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Rosina A. Hoernell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant Frank P. Lutz (Address) Hamilton & Hazelwood Aves

15 Filed ....., 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1921 to Nov. 26, 1922.

that I last saw h alive on ....., 19 .....,

and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lithargic

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) J. C. Rumbarger, M. D.

(Address) 1531 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Nov. 28 1922

20 UNDERTAKER Fredk Lucas & Son — ADDRESS Fullerton

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Nov 27 1922

Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Fugman)

D69533

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69533

CERTIFICATE OF DEATH.

11-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hop ST. 21 WARD)

2-FULL NAME Henry M. Fugman

(a) RESIDENCE. No. 1202 Cleveland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Trevia E. Fugman

6 DATE OF BIRTH (month, day, and year) Sept 13, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer) P. & O. R. R. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Benjamin Fugman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Trevia E. Fugman

(Address) 1202 Cleveland St.

15 Filed ....., 19.... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1922, to Nov 25th, 1922, that I last saw h alive on Nov 24, 1922, and that death occurred, on the date stated above, at 1:19 m.

The CAUSE OF DEATH* was as follows:

Acute Lobular Diffusion over

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Ellen Grantham, M. D.

11/25, 1922 (Address) 517 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Freedom Cemetery	Nov 28, 1922
20 UNDERTAKER E. LeRoy Stuffle	ADDRESS 125 E. North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D69534 HEALTH DEPARTMENT—CITY OF BALTIMORE D69534

CERTIFICATE OF DEATH.

161-002

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. West End Maternity Hosp. WARD) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Hauck.

(Residence in Baltimore: No. West End Maternity Hosp St.; ....yrs., ...mos. ....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Fem.	W	

6-DATE OF BIRTH, Nov. (Month) 26, (Day) 1922 (Year)

7-AGE, ...yrs. ....mos. ....ds. If LESS than 1 day, 1 hrs. or 30 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Thomas Shyrock Hauck

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Ella Davis

13-BIRTHPLACE OF MOTHER (State or Country), Winston Salem N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. R. Shoumberger R.N.

(Address) 112 S. Ballhouse St.

15-

Robert E. Harrison,

Filed....., 191.... Burial Permit Clerk. Registrar.

NOV 27 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 26 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 1922, to Nov 26 1922, that I saw h alive on Nov 26 1922, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity Labor Cyanosis

Pneumonia Followed by

Spasms Asphyxia

..... (Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) ....yrs. ....mos. 2 ds.

(Signed) Edward Zeller M.D.

Nov 26, 1922 (Address) 1232 Fremont Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Lorraine Cemetery	Nov. 28th, 1922
20-UNDERTAKER Wilson W. Lewis	ADDRESS Ave. 1018 Edmondson

D69535 HEALTH DEPARTMENT—CITY OF BALTIMORE D69535

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 327 So. Chester St., 1 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Majeska

(Residence in Baltimore: No. 327 So. Chester St.; yrs. ..... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Nov. 26 (Month) (Day) 1922 (Year)

7-AGE: — yrs. — mos. — ds. If LESS than 1 day, — hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of Industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country): Balto, Md

PARENTS.

10-NAME OF FATHER: Czelaw Majeska

11-BIRTHPLACE OF FATHER, (State or Country): Europe

12-MAIDEN NAME OF MOTHER: Genevieve Kuczner

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Genevieve Majeska

(Address) 327 So. Chester St

15-

Filed ..... 192 .....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Nov. (Month) 26 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Norton M. D.
(Coroner.)

Nov 27 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal, or Homicidal.

Balto, Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Rosary — DATE OF BURIAL: Nov 28 1922

20-UNDERTAKER: John W. Weber — ADDRESS: 1803 Bank St

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D69536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69536

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 163 N Hanburg. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Loretta K. Gardner

(a) RESIDENCE NO. 163 N Hanburg. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan. 16 1906

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
16	10	8	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Otto. Gardner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Theresa Schoberg.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Otto Gardner. (Father)

(Address) 163 N Hanburg St

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 24 1922

17 I HEREBY CERTIFY, That I attended deceased from 11/3, 19 22, to 11/24, 19 22,

that I last saw h alive on 11/24, 19 22

and that death occurred, on the date stated above, at 10 10 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Rheumatism

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Mitchell, M. D.

11/24, 19 22 (Address) 1209 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross C. C. — DATE OF BURIAL 11-28 1922

20 UNDERTAKER Earl B Hale — ADDRESS 115 E West St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 27 1922

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69537

CERTIFICATE OF DEATH.

90

D69537

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2735 St. Ward)

2-FULL NAME Alice J. Stewart

(Residence in Baltimore: No. 2735 Maryland ave St.; yrs. 35 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	married

6-DATE OF BIRTH, Nov 19 (Month) (Day), 1859 (Year)

7-AGE, 63 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home worker
(b) General nature of industry, business, or establishment in which employed (or employer): Chemical Laundry

9-BIRTHPLACE. (State or Country), Md

PARENTS.

10-NAME OF FATHER, James Brady

11-BIRTHPLACE OF FATHER (State or Country). Irel

12-MAIDEN NAME OF MOTHER Mary Solomon

13-BIRTHPLACE OF MOTHER (State or Country). Germ

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. B. M. Burnam

(Address) 2735 Maryland ave

15-

Filed NOV 27 1922, 191

Robert P. Harrison,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 26 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained at said inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Harrison M. D.
(Coroner.)

Nov 27, 1922 (Address) 632 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Nov 28, 1922

20-UNDERTAKER	ADDRESS
Wilbur W. Stevens	1018 Eutaw pl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 27 1922

D69538 HEALTH DEPARTMENT--CITY OF BALTIMORE **D69538**

CERTIFICATE OF DEATH

124 19

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No 1703 McHenry St. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret Kober

(Residence in Baltimore: No. 1703 McHenry St.: 19 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Unknown (Month), , 1862 (Year) (Day)

7 AGE: 60 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Hungary

PARENTS

10 NAME OF FATHER: — Martin

11 BIRTHPLACE OF FATHER (State or country): Hungary

12 MAIDEN NAME OF MOTHER: — Rotenbach

13 BIRTHPLACE OF MOTHER (State or country): Hungary

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Michael J. Jantz
(Address) 1703 McHenry St

15 Robert P. Harrison,
Filed , 191
Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August 26, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1919, to Nov 26 1922
that I saw her alive on Nov 26, 1922
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Catarrh.

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) Exhaustion

(Duration) yrs. mos. ds.

(Signed) Sylvester Dell M. D.

Nov 27, 1922 (Address) 1433 Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Cathedral | DATE OF BURIAL: Nov 28 1922

20 UNDERTAKER: Harry H. Fitzlee | ADDRESS: 1531 W. Lombard

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69539

CERTIFICATE OF DEATH.

88 ✓

D69539

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1444 Light St. ST., 23 WARD)

2-FULL NAME Marian H. Eberhardt

(a) RESIDENCE No. 1444 Light St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 5 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) june 16 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	16	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Leesburg Va.
(State or country)

PARENTS

10 NAME OF FATHER William Wiley

11 BIRTHPLACE OF FATHER (city or town) Leesburg Va.
(State or country)

12 MAIDEN NAME OF MOTHER Rosie I. Brown

13 BIRTHPLACE OF MOTHER (city or town) Leesburg Va.
(State or country)

14 Informant Mrs. Pauline Eberhardt
(Address) 1444 Light St.

15 NOV 28 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11.26 1922

17

I HEREBY CERTIFY, That I attended deceased from 11.24.22, 19, to 11.26.22, 19,

that I last saw her alive on 11.26.22, 19,

and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos ds.

over

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinicd only

(Signed) Pauline V. Faulen M. D.

11.27.22 (Address) 1438 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 11/28 1922

20 UNDERTAKER: J. Frew McCully

ADDRESS: 130 E. Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69540 D69540

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 561 Orchard ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda Owens

(a) RESIDENCE NO. 561 Orchard ST., ( ) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 25. 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
F	20	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER (Charles) Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER — Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Rachel Jackson) (Address) 561 Orchard St

15 Filed NOV 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1922

17 I HEREBY CERTIFY, That I attended deceased from November 1 to , 19 ,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at 8:45 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. Hemmeter M. D.

, 19 (Address) Health Department

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Not Embalmed

DATE OF BURIAL 11/29 1922

20 UNDERTAKER Samuel J. Hemelright

ADDRESS 518 E. Biddle

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69541

D69541

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2321 Druid Hill ST.: 13 WARD)

2-FULL NAME William Daniel Dolman

(a) RESIDENCE. NO. 2321 Druid Hill ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Dolman

6 DATE OF BIRTH (month, day, and year) March 8, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Pennsylvania Railroad

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Israel Dolman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Windsor Nova Scotia Canada

12 MAIDEN NAME OF MOTHER Anne E. Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis, Md.

14 Informant (Address) Jerome Wm. P. Dolman 406 Fairmount Ave Towson

15 Filed NOV 28 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1922, to Nov. 25, 1922, that I last saw h[illegible] alive on Nov. 24, 1922, and that death occurred, on the date stated above, at 3.40 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Sub Acute Bronchitis Porter

Pa Station Toilet (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William D. Knight M. D.

Nov 25, 1922 (Address) 120 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	11/28 1922

20 UNDERTAKER Samuel T. Hamilton ADDRESS 578 W Biddle

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69542 90 **D69542**

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Druid Hill Av ST.: 11 WARD)

2-FULL NAME Jennie M. Adams

(a) RESIDENCE. NO. 1119 Druid Hill Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widow

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66 ~~66~~			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eastern Shore Md

PARENTS

10 NAME OF FATHER Levi Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore Md

12 MAIDEN NAME OF MOTHER Josie Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore Md

14 Informant Florence Richardson
(Address) 1119 Druid Hill Ave

15 FILED NOV 28 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 192 2

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1922, to Nov. 26, 1922.

that I last saw her alive on Nov. 26, 1922.

and that death occurred, on the date stated above, at 3:20 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Wheatley, M. D.

11/28 1922 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 11/29 1922

20 UNDERTAKER Samuel Schneider

ADDRESS 578 W Baltimore St

D69543

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D69543

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 549 Ostend St. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Peterson

(Residence in Baltimore: No. 549 Ostend St. St.; yrs., mos., ds.)

Denis Krum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced (Write the word.): single

6-DATE OF BIRTH: about (Month) (Day) 1862 (Year)

7-AGE: about 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Denis Krum

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Toadvine

(Address) 141 W. Hill St.

15 Filed NOV 28 1922 192 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 25 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): no history

(Duration) yrs. mos. ds.

(Signed) J. F. Hennessy M. D.
(Coroner.)

Nov. 27 1922 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Nov. 28 1922

20-UNDERTAKER: John H. Toadvine — ADDRESS 142 Ostend St

Spec.—1-10-21 M&T 1500 Blks.

Maasberg.

D69544

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69544

44

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Inf.

CITY OF BALTIMORE: (No.) Broadways Fair mont ST., 10 WARD)

2-FULL NAME Mr. Christopher Maasberg.

(a) RESIDENCE NO. 836 Asquith St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Pauline Maasberg

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1852

7 AGE 70 Years | Months | 20 Days | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Taylor 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Schloss Bros.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Charles Maasberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William C Maasberg
(Address) 836 Asquith St

15 NOV 28 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov. 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1922 to Nov 26, 1922.

that I last saw him alive on Nov. 26, 1922.

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach
& Metastases Liver

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis Clinical methods

(Signed) Richard F. Corbett, M. D.

, 19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Immanuel Cemetery — DATE OF BURIAL Nov 30 1922

20 UNDERTAKER Louis Heimann — ADDRESS 325 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69545 HEALTH DEPARTMENT—CITY OF BALTIMORE D69545

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Praeger

(a) RESIDENCE NO. 324 S. Fremont ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hardwood finisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Praeger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kate Shidet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records (Address) H.T.H.

15 NOV 28 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1922, to Nov. 27, 1922, that I last saw him alive on Nov. 27, 1922, and that death occurred, on the date stated above, at 7.20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Dalgliesh M. D.

11-28-1922 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery DATE OF BURIAL Nov 28 1922

20 UNDERTAKER Fred A. Krause & Son ADDRESS 703 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dyson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69546

CERTIFICATE OF DEATH.

9

D69546

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 Whatcoat St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Dyson Jr

(a) RESIDENCE. No. 908 Whatcoat St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Oct 1921

7 AGE: Years ~~Oct 1921~~ Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Thos Dyson Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Margaret Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs. Dyson
(Address): 908 Whatcoat St.

15 Filed NOV 28 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 25 1922

17 I HEREBY CERTIFY, That I attended deceased from 11-22-, 192, to 11-25, 1922, that I last saw h in alive on 11-25-, 192, and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Asthma

over

(duration) yrs. 7 ds

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. mos. 2

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W R Taylor, M. D.

, 19 (Address) 1618 Caldon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Nov. 28 19

20 UNDERTAKER: Samuel A Dennis

ADDRESS 1313 Goodman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

probably whooping cough (about 5 months ago).

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69547

CERTIFICATE OF DEATH.

161-001

D69547

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 St Helena ave ST.; 26 WARD)

2-FULL NAME Patrick Magann

(a) RESIDENCE. No. 311 St Helena ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 hrs ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 27-1922

7 AGE — Years — Months — Days — If LESS than 1 day, 4 hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Galvin Magann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Marie E. Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Street Md.

14 Informant John J Magann

(Address) 311 St. Helena ave.

15 Filed NOV 28 1922 19 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 27, 1922, to Nov 27, 1922, that I last saw h[illegible] alive on Nov 27, 1922, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) 4 hrs yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Arvo Saier, M. D.

(Address) 1 Township Rd. Towson Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 11/28/ 19

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Harford Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69548

D69548

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1664 W Fayette St. 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Iraq S. Raymond

(Residence in Baltimore: No. 1664 W Fayette St. 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Aug (Month) 19 (Day) 1886 (Year)

7-AGE: 36 yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): General Electric Co

9-BIRTHPLACE, (State or Country): New York City

PARENTS.

10-NAME OF FATHER: Wm H Raymond

11-BIRTHPLACE OF FATHER, (State or Country): New York City

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): New York City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose C. Raymond

(Address) 1664 W Fayette St

15- Filed NOV 28 1922 ROBERT R. KRAUS Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 26 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture at base of Skull by falling down Cellar Stairs at his home accident

(Duration) ....yrs. Instantaneous

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James McFenton M. D. (Coroner.)

Nov 27 1922 (Address) 700 E Eager St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

1664 W Fayette St

Former or usual residence 1664 W Fayette St

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, Nov 29 1922

UNDERTAKER, F. S. Keyser 2336 Eutaw Ave ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69549 HEALTH DEPARTMENT—CITY OF BALTIMORE

11-007

D69549

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mc Shane Bell Foundry St., Hopkins Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Jaskolski

(Residence in Baltimore: No. 224 S. Ann St St.; yrs. 46 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, ... 1884
(Month) (Day) (Year)

7-AGE, 75 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) McShane Bell Foundry

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country), Poland

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jan Mary Jaskolski Wife

(Address) 224 S Ann St

15- Filed NOV 28 1932, 192.... ROBERT R. KRAUTER Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 25, 1932.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. Inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Acute Pneumonia Contributory

(Natural Causes)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ..... yrs. 7 mos. 8 ds.

(Signed) J. S. Dalton M. D.
(Coroner.)

11-27 1932 (Address) 526 E Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Dolphy Rosary DATE OF BURIAL, Nov 30 1932

20-UNDERTAKER, John Snadeker ADDRESS 1803 Bank St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69550

CERTIFICATE OF DEATH.

74 601

D69550

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 250 N Schroeder ST., 18 WARD)

2-FULL NAME Rosie Ferguson

(a) RESIDENCE No. 250 N Schroeder ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Isaiah Ferguson

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 67 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General house work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

070

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co Md

PARENTS

10 NAME OF FATHER: Lazzley Benson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anne Arundel Co Md

12 MAIDEN NAME OF MOTHER: Rachel Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundel Co Md

14 Informant: Isaiah Ferguson

(Address) 250 N Schroeder St

15 NOV 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1922, to Nov 26, 1922, that I last saw h[illegible] alive on Nov 25, 1922, and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Howard M. D.

11/28/1922 (Address) 1921 Arrington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] Cemetery Co — DATE OF BURIAL: Nov 28 1922

20 UNDERTAKER: Brown & Buckland — ADDRESS 1140 W. Lexington

Spec.—1-10-21—M&T—1500 Bks.

D69551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69551

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2027 E. 31st ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Harsch

(a) RESIDENCE NO. 2027 E. 31st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ late Bertha A. Harsch

6 DATE OF BIRTH (month, day, and year) July 9 - 40

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or empioyer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Jacob Betz Jr.

(Address) 2027 E. 31st

15 Filed NOV 28 1922 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 25 1922

17 I HEREBY CERTIFY, That I attended deceased from June, 1922, to Nov. 25th 1922, that I last saw h~~im~~ alive on Nov. 25th, 1922, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis.

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) — yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robert S. Kirk, M. D.

11/27/1922 (Address) 3126 Basford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 11/28 1922

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Aliceanna

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69552

CERTIFICATE OF DEATH.

164 D69552

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3716 Barrington Rd ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Everett Everett

(a) RESIDENCE NO. 3716 Barrington Rd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma V. Everett

6 DATE OF BIRTH (month, day, and year) May 19 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	79	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Thos. J. Everett

11 BIRTHPLACE OF FATHER (city or town) New Jersey
(State or country)

12 MAIDEN NAME OF MOTHER Mary Bryan

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Thos. J. Everett
(Address) 3716 Barrington Rd

15 Filed NOV 28 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Six Months ago, 19 .... to Nov 27, 19 22, that I last saw him alive on Nov 27, 19 22, and that death occurred, on the date stated above, at 3 30 m

The CAUSE OF DEATH* was as follows:

General Debility

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Burnett A Carter, M. D.

, 19 (Address) 1404 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Nov 29 1922

20 UNDERTAKER J. H. Sumwalt ADDRESS Monroe

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69553

CERTIFICATE OF DEATH.

47

D69553

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Md. General Hosp. 13 WARD)

2-FULL NAME Katherine ~~Rose~~ Arnold

(a) RESIDENCE NO. 2300 Avalon Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	wht.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of never

6 DATE OF BIRTH (month, day, and year) March 27 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	62	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) germany

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant (Address)

15 Filed NOV 28 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1922 to Nov 27, 1922 that I last saw h[illegible] alive on Nov 27, 1922 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows: carcinoma of the breast

(duration) over 5 yrs. mos da.

CONTRIBUTORY (Secondary) Involvement of lung (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) J H Welkerson M. D.

, 19 (Address) Union Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 29, 22

20 UNDERTAKER W. J. Sanderson

ADDRESS north Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69554

CERTIFICATE OF DEATH.

129 D69554

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Apts ST., W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Schott

(a) RESIDENCE NO. Homewood Apts ST., 12 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 5 mos. 14 ds. How long in U. S., If of foreign birth? 53 yrs. 5 mos. 14 ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Taney Schott

6 DATE OF BIRTH (month, day, and year) May-13-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance 071

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer E. J. Richardson Sons

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Schott

11 BIRTHPLACE OF FATHER (city or town) Frankfurt (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Schroeder

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Hedwig T. Schott (wife) (Address) Homewood Apts.

15 NOV 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2 1922, to Nov 27 1922, that I last saw him alive on Nov 27 1922, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchi-pneumonia

(duration) — yrs. — mos 28 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and Chronic Interstitial Nephritis unknown (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) Charles Getz, M. D.

Nov 27 1922 (Address) 111 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cemetery	Nov-29-1922
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AV

Spec.—1-10-21—M&T—1500 Bks.

D69555 HEALTH DEPARTMENT—CITY OF BALTIMORE D69555

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930-W. Franklin ST., 18 WARD)

2-FULL NAME Charles Albert Spicknall

(a) RESIDENCE NO. 930-W-Franklin ST., 18 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 71 yrs. 8 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliza C. Spicknall

6 DATE OF BIRTH (month, day, and year): Feby-28-1851

7 AGE: Years 71 Months 8 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor & Builder

(b) General nature of industry, business, or establishment in which employed (or employer): C. A. Spicknall Sons

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Calvert Co. Md.

PARENTS

10 NAME OF FATHER: Thomas Spicknall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co. Maryland.

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Probably, Calvert Co. Md.

14 Informant: Mr. W. O. Spicknall- (son)

(Address): 930-W-Franklin-St.

15 Filed NOV 28 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 5th, 1922, to Nov 26th, 1922.

that I last saw him alive on 26th Nov, 1922,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

High blood pressure contributory

(duration) Hungry yrs. ? mos ? ds.

Uremia immediate death

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. H. Hill, M. D.

11.27. 1922 (Address) 1208 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Nov-29-1922

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AV

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ABBREVIATIONS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69556 HEALTH DEPARTMENT—CITY OF BALTIMORE D69556

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 N. Monroe ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Roszel Englar

(a) RESIDENCE NO. 1104 N. Monroe ST., 16 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 61 yrs. 11 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec 11 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Natl Central Bank.

(c) Name of employer Natl Central Bank

9 BIRTHPLACE (city or town) New Windsor

(State or country) Carroll Co. Md

PARENTS

10 NAME OF FATHER Mordicai Englar

11 BIRTHPLACE OF FATHER (city or town) New Windsor

(State or country) Carroll Co. Md

12 MAIDEN NAME OF MOTHER Lavinia Paxton

13 BIRTHPLACE OF MOTHER (city or town) Fredonia

(State or country) Frederick Co. Md

14 Informant Mrs Mary E. Hibbard (Sister)

(Address) 1104 N Monroe St

15 Filed NOV 23 1922, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1922, to Nov 26, 1922, that I last saw him alive on Nov 25, 1922 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Left sided Hemiplegia

(apoplexy)

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Chron. Nephritis

(duration) unknown yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chas. C. Conser, M. D.

11/26, 1922 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Nov-28-1922

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT R
mation should be carefully supplied. AGE should be stated EXACTLY
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69557

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Anthony Sebastian Barbaro

(a) RESIDENCE NO. ..... Memphis, Tennessee ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	68	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Italy

PARENTS

10 NAME OF FATHER Anton Barbaro

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Italy

12 MAIDEN NAME OF MOTHER Catharine Brizzolara

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Italy

14 Informant ..... (Address) Johns Hopkins Hospital Records

15 NOV 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27th 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24th, 19 22 to Nov 27th 1922.

that I last saw h(e)(a)live on Nov. 27th 1922.

and that death occurred, on the date stated above, at 5-45 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of stomach

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. Bond mos ..... ds.

(duration) yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Nov 25/22

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Harris E Kapp, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Memphis Tennessee

DATE OF BURIAL 11/28 19 22

20 UNDERTAKER Henry Meulkins Sons Co

ADDRESS Orchard & Eutaw Sts.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

159730

D69558

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D69558

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 11 WARD)

2-FULL NAME Mrs Caroline Halstead.

(a) RESIDENCE No. 1201 Eutaw Place, Balto. Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 Yrs 0 mos unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~, ~~HUSBAND~~ (or) WIFE of Dr William A Halsted ~~Living Husband~~ (Name),

6 DATE OF BIRTH (month, day, and year) Nov. 29 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	61	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Frank Hampton

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Sallie Baxter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed NOV 28 1922 ROBERT P. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1922, to Nov. 27, 1922, that I last saw her alive on Nov. 27, 1922, and that death occurred, on the date stated above, at 12.00 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(duration) ... yrs. mos 8 ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test.

(Signed) Hibbard Brown, M. D.

11-27, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Columbia S. C.

DATE OF BURIAL 11-28 1922

20 UNDERTAKER Henry A Jenkins & Sons Co

ADDRESS McCulloh & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

69559

CERTIFICATE OF DEATH.

74-001 D69559

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 N. Calhoun ST., 19 WARD)

2-FULL NAME Maria Dittmar

(a) RESIDENCE NO. 516 N. Calhoun ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 79 yrs. -- mos. -- ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Dittman

6 DATE OF BIRTH (month, day, and year) Oct. 24, 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	89	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Winter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William A. Codd

(Address) 3510 Clifton Avenue

15 NOV 28 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/25 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/10, 1922, to 11/25, 1922, that I last saw h[illegible] alive on 11/25 1922 and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis.

(Senility)

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema (Extinction) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W. B. Mears, M. D.

11/27, 1922 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 11/ 1922

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Lillian Butler ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69560 D69560

CERTIFICATE OF DEATH.

Registered No. C. 181-003

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Lillian Butler

(Residence in Baltimore: No. 1308 N. Chester St. St.; yrs., 11 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Col	Single

6-DATE OF BIRTH. Don't Know (Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
9 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). N. Carolina

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). N.C.

12-MAIDEN NAME OF MOTHER. Lillian Ford

13-BIRTHPLACE OF MOTHER, (State or Country). N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Claude Butler

(Address) 1308 N. Chester St.

15- NOV 28 1922 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 26 (Month) (Day) 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Arteriosclerosis, she was brought to the County Hospital suffering from

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

11 28 192 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence North Carolina

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn	Nov 28 1922
20-UNDERTAKER.	ADDRESS.
Daniel Easton	916 Pa Ave

Spec.—1-10-21—M&T—1500 Bks.

D69561 HEALTH DEPARTMENT—CITY OF BALTIMORE **D69561**

94001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3rd Ave. nr Cole St. or Ward) Rasp. (WARD) 10a

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan V. Harris

(a) RESIDENCE No. Third Ave. Raspeburg WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan. 26, 1853

7 AGE Years	Months	Days	If LESS than 1 day, .. hrs. or .. min.
69	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James J.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosella Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Anna M. Harris (Address) 3rd ave. Raspeburg

15 NOV 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 25th 1922, to Nov 27, 1922, that I last saw h[illegible] alive on Nov 27, 1922, and that death occurred, on the date stated above, at 2 20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Edw. A. Benson M. D.

, 19 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Davisonville, A.A. Co. Md	11/30/ 1922
20 UNDERTAKER	ADDRESS
Wm. Cook,	50 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Farrell) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69562

CERTIFICATE OF DEATH.

11-04

D69562

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Carey, ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Farrell

(a) RESIDENCE. No. 1613 Carey St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) April 1861

7 AGE Years 61 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Martin Kavanagh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Geo. J. Farrell

(Address) 1613 E. Carey St

15 Filed NOV 28 1922 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1922, to Nov 26, 1922, that I last saw h alive on Nov 26, 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia. Cva

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. F. McKenna, M. D.

, 19 (Address) 1353 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral 11/29

DATE OF BURIAL 19

20 UNDERTAKER Wm. Cook, 50 E. North ave.

ADDRESS

N. B.—WRITE PLAINLY, WITH CAPITAL LETTERS. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69563 D69563

CERTIFICATE OF DEATH. X 91-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 E Cross ST. 24 WARD)

2-FULL NAME Joseph Davis Seymour

(a) RESIDENCE NO. 121 E Cross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Linda W Seymour

6 DATE OF BIRTH (month, day, and year) Oct 30 1858

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
64	-	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter for 015

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Steamslipt

(c) Name of employer Packing Co

9 BIRTHPLACE (city or town) Chatham Co

(State or country) North Carolinia

PARENTS

10 NAME OF FATHER Joseph Seymour

11 BIRTHPLACE OF FATHER (city or town) Don't Know

(State or country)

12 MAIDEN NAME OF MOTHER Betsy Abernathy

13 BIRTHPLACE OF MOTHER (city or town) Chatham Co

(State or country) North Carolina

14 Informant Mrs Linda W Seymour

(Address) Norfolk Va

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

NOV 28 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 15, 1922, to Nov 27, 1922, that I last saw him alive on Nov 27, 1922, and that death occurred, on the date stated above, at 1 30 a m.

The CAUSE OF DEATH* was as follows:

Artero Sclerosis

Contributory (Secondary) Duration yrs. 3 mos ds.

Chronic Myocarditis Duration yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Henry B Mollan, M. D.

Nov 27/22 (Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va — DATE OF BURIAL Nov 28 1922

20 UNDERTAKER John H Denny — ADDRESS 715 Light St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69564

D69564

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 573 S Chester ST., 1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Hennegan

(a) RESIDENCE NO. 573 S Chester ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer OHO

(b) General nature of industry, business, or establishment in which employed (or employer) Laundry

(c) Name of employer The Sun Bell Laundry

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Hennegan

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Kilcullen

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant (Address) Mrs Mary Hennegan 573 S Chester St

15 Filed Nov 28 1922, 19 ..... Robert ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 19 22, to Nov 26, 19 22,
that I last saw h(e) alive on Nov 26, 19 22
and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Manuel F Worthington, M. D.

, 19 22 (Address) 332 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	11/29 1922
20 UNDERTAKER	ADDRESS 300 E Baltimore
J A Moran	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. F. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69565

CERTIFICATE OF DEATH.

D69565

REGISTERED NO. X 155

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No.) ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeff Lester Henry

(a) RESIDENCE. NO. Lancaster S. C ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Henry

6 DATE OF BIRTH (month, day, and year): June 21-1882

7 AGE — Years: 40 Months: 4 Days: 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Lancaster S.C.

PARENTS

10 NAME OF FATHER: David Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lancaster S.C.

12 MAIDEN NAME OF MOTHER: Emma Jane Ellerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lancaster S.C.

14 Informant (Address):

15 Filed NOV 28 1922 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from 11-18 22. 1922, to 11-28 1922,

that I last saw h(er) alive on 11-28 1922

and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicemia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Tumor of Bone

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-20-22

Was there an autopsy?

What test confirmed diagnosis? Blood Culture

(Signed) D. N. Hudson, M. D.

11/28, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lancaster S.C.

DATE OF BURIAL: 11/28 1922

20 UNDERTAKER: Jack Lewis

ADDRESS: 1434 E Baltimore

N. B.—WRITE PLAINLY, WITH CARBON INK.—This is a BUSINESS RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69566 — CERTIFICATE OF DEATH. — 74-001 — D69566

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. Monument St. ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Kate Livingston.

(a) RESIDENCE. No. 1947 Penna ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Livingston

6 DATE OF BIRTH (month, day, and year): September 1870

7 AGE: 52 Years Months Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Morris Goldenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Celia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1434 E Baltimore

15 Filed: Robert P. Harrison, Registrar

Burial Permit Clerk.

NOV 28 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 27 1927

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27. 19 27, to Nov. 28 19 27,

that I last saw h[illegible] alive on Nov. 26. 19 27,

and that death occurred, on the date stated above, at 1 [illegible] 7 m.

The CAUSE OF DEATH* was as follows:

Cerebral, Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): arterio sclerosis + hypertension

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? [illegible], Date of

Was there an autopsy? no

What test confirmed diagnosis? clinically

(Signed) Moses Seelman, M. D.

, 19 (Address) Hebrew Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 11/29 19 27

20 UNDERTAKER: Jack Lewis — ADDRESS: 1434 E Baltimore St

B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69567

CERTIFICATE OF DEATH.

57 D69567

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Madison Av ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Albert Paca

(Residence in Baltimore: No. 1401 Madison Av St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., (Month) (Day) 1877 (Year)

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John P Paca

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Horace Keys

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A K Paca

(Address) 219 Oak St

15-

Filed Nov 28 1922 Robert F Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 27 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 24 1922, to Nov 27 1922, that I saw h in alive on Nov 27 1922, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions, 1/2 hour

(Duration) yrs. mos. ds.

(Signed) Joseph E Gichner M. D.

Nov 28 1922 (Address) 1 E Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? y e

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Lawn — DATE OF BURIAL, Nov 29, 1922

20-UNDERTAKER Henry W Jenkins Sons — ADDRESS Cathedral & Centre Sts

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69568

CERTIFICATE OF DEATH.

D69568

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3407 Foster Ave ST., 26 WARD)

2-FULL NAME Mary F. Schneider

(a) RESIDENCE NO. 3407 Foster Ave ST., 26 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Schneider

6 DATE OF BIRTH (month, day, and year) March 24 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Leonard Frisch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Schneider

(Address) 3407 Foster Ave

15 Filed ..... 19 ..... Registrar Robert P. Garrison

NOV 28 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1922 to Nov 26 1922

that I last saw h alive on Nov 25 1922

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M J McAvoy M. D.

1/26/1922 (Address) 839 S. Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Nov. 29 1922

20 UNDERTAKER Lilly and Zeiler

ADDRESS 403 S. Wolfe St

B.—WRITE PLAINLY, WITH UNFADING INK. THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69569

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69569

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE (No. 373 So. Edw St., 3 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Taccone

(Residence in Baltimore: No. 373 So. Edw St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Unknown ..... 1..... (Month) (Day) (Year)

7-AGE. About 41 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Italy

PARENTS.

10-NAME OF FATHER: Dominick Taccone

11-BIRTHPLACE OF FATHER, (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Creadoffer

(Address) 373 So. Edw St.

15- Filed ..... 192.....

Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 27 192.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows: Internal Hemorrhage Caused by Pistol wound

(Duration) ..... yrs. ..... mos. ..... ds. at once

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. P. Morton M. D.

(Coroner) Nov 28 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Gun Shot Wound

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Vincents	Nov 29 1922
20-UNDERTAKER.	ADDRESS
Wendel Dippold	373 S. Conn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69570 D69570

CERTIFICATE OF DEATH.

159-002

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1905 E Eager ST.; 7 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Klonia

(Residence in Baltimore: No. 1905 E Eager St.; yrs. 2 mos. 4 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	

6-DATE OF BIRTH, August 16, 1920
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Joseph Klonia

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Anna Smrha

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Klonia

(Address) 1905 E Eager St

15- NOV 29 1922 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 27th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20th 1922, to Nov 27 1922, that I saw her alive on Nov. 27, 1922, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Non Development of Blood
It was born a blue Child
Heart not Developed
(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Perfectly developed
Suddenly on above date
(Duration) ...yrs. ...mos. ...ds.

27 November 1922
(Signed) Thos. Simms M. D.
Nov. 28 1922 (Address) 1 E. N. Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer

DATE OF BURIAL. Nov 30, 1922

20-UNDERTAKER Grant & Grace

ADDRESS 1916 E Monument

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1598[illegible]
D69571

CERTIFICATE OF DEATH.

X44 D69571

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Clifton Hill

(a) RESIDENCE NO. Greenbarry Co. W. Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lafayette Hill

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greenbarry Co W. Va

PARENTS

10 NAME OF FATHER Andrew Jackson Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greenbarry Co W. Va

12 MAIDEN NAME OF MOTHER Pauline Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Edward Hill
(Address) West Va

15 NOV 29 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 28-11 Am. 1922. to Nov 28-11 Pm. 1922.
that I last saw him alive on Nov 28-11 Pm, 1922,
and that death occurred, on the date stated above, at 11((m.
The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) 1/2 yrs. mos ds.

CONTRIBUTORY (Secondary) Operation

(duration) 11 Days mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Nov 28

Was there an autopsy? yes Partial

What test confirmed diagnosis? Operation

(Signed) A. Blakemore, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Meadow Creek West Va — DATE OF BURIAL Nov 24 1922

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Burg

N. B.—WRITE PLAINLY, WITH INK OR INDELIBLE PENCIL. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69572

1-PLACE OF DEATH

CERTIFICATE OF DEATH. 113

D69572

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1120 Mc Culloh ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Jackson

(Residence in Baltimore: No. 1120 Mc Culloh St.; — yrs., 5 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, June 6, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 5 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto., Md -

PARENTS.

10-NAME OF FATHER, Wm Jackson

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Bertha ~~Bertha~~ Fisher

13-BIRTHPLACE OF MOTHER (State or Country), Balto., Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Jackson Sr

(Address) 1120 Mc Culloh St

15- Filed NOV 29 1922, 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 28, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1922, to Nov 28 1922, that I saw her alive on Nov 28 1922, and that death occurred, on the date stated above, at 1 2 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Congestion

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) —

(Duration) ....yrs. ....mos. ....ds.

(Signed) John D. Krieg M. D.

Nov 28, 1922 (Address) 1425 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt. Auburn Cemetery — DATE OF BURIAL, Nov. 29th, 1922.

20-UNDERTAKER Jno. M. Johnson — ADDRESS 1239 Eutaw St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks Probably due to Intestinal Indigestion
for Lunatic Asylum.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Bks.

D69573

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D69573

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 E. Biddle ST., 8 WARD)

2-FULL NAME Julius Meister

(a) RESIDENCE NO. 1519 E. Biddle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Meister

6 DATE OF BIRTH (month, day, and year) Jan. 22. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) Julius P. Meister 1519 E. Biddle St

15 FILED NOV 29 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1922

17 I HEREBY CERTIFY, That I attended deceased from 11/19—, 19 22, to 11/27/22, 19 22, that I last saw h live on 11/26/22, 19 ..., and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Emphysema

(duration) 10 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. H. Herrmann, M. D.

..., 19 ... (Address) 919 South St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Nov. 29 1922

20 UNDERTAKER H. Lander Sons ADDRESS 1710 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D69574

D69574

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2935 E. Monument ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Repp

(a) RESIDENCE NO. 2935 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Repp

6 DATE OF BIRTH (month, day, and year) May 17, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER John Rathgeber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Alles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Repp (Address) 2935 E. Monument St.

15 NOV 29 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1922 to Nov. 25, 1922, that I last saw h[illegible] alive on Nov. 25, 1922, and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) C. A. Meyer Jr. M. D.

11/25, 1922 (Address) 2638 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pimlico Cemetery DATE OF BURIAL Nov. 29 1922

20 UNDERTAKER H. Sander Sons ADDRESS 1910 Pratt

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69575

CERTIFICATE OF DEATH.

38 1

D69575

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., No WARD)

2-FULL NAME Albert Fisher

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	? abt 70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records.

(Address)

15 Filed NOV 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1922

17

I HEREBY CERTIFY, That I attended deceased from November 11, 1922, to November 27, 1922,

that I last saw him alive on November 27, 1922,

and that death occurred, on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH* was as follows:

Uremia Paresis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.

11/28/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL Nov. 29 1922

20 UNDERTAKER H. Sander Sons

ADDRESS 1710 Read

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69576
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D69576
Registered No. C.....

City of BALTIMORE: (No. 200 Ivy alley St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nonny Fol

(Residence in Baltimore: No. 1207 Ivy alley St.; 20 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	Colored	Don't Know

6-DATE OF BIRTH. Don't Know, 1.....
(Month) (Day) (Year)

7-AGE. 59 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundry
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Child

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER, (State or Country), " "

12-MAIDEN NAME OF MOTHER, " "

13-BIRTHPLACE OF MOTHER, (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nonny Fol

(Address) 230 Park ave

15-
Filed, 12 9 1922 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 28, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

..... 192.... (Address) .....

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore	Nov 30, 1922
20-UNDERTAKER. John F. Denny	ADDRESS. 715 Light St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69577

CERTIFICATE OF DEATH.

161-001 D69577

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 E. Lafayette ave St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Daughter of Harry & Laura Kohler

(Residence in Baltimore: No. 1407 E Lafayette ave St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, Nov (Month) 26 (Day), 1922 (Year)

7-AGE, ...yrs. ....mos. 2 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). 1407 E Lafayette ave

PARENTS.

10-NAME OF FATHER, Harry Kohler

11-BIRTHPLACE OF FATHER (State or Country). Baltimore md

12-MAIDEN NAME OF MOTHER Laura Fiet

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Kohler

(Address) 1407 E. Lafayette ave

15- Filed NOV 29 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 28 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 26 1922, to Nov 28 1922, that I saw her alive on Nov 27 1922, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) E. C. Duncan M. D.

Nov 28, 1922 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Stone Chapel Cemetery

DATE OF BURIAL, Nov 29, 1922

20-UNDERTAKER J. F. Elvin

ADDRESS Reisterstown

N. B.—Every item of information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69578

90 D69578

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 N. Pat. Pk. Ave. St.) (8 WARD)

2-FULL NAME Margaret Lowry

(a) RESIDENCE NO. 1010 N. Pat. Pk. Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Andrew G. Lowry

6 DATE OF BIRTH (month, day, and year) Aug 12- 65

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Magherfelt Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Andrew G. Lowry

(Address) 1010 N. Pat. Pk. Ave

15 Filed NOV 23 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 27 1922

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1922, to Nov. 27, 1922, that I last saw h alive on Nov. 27, 1922, and that death occurred, on the date stated above, at 10 4 m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy; with Valvular trouble.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) A. F. Robinson M. D.

11-28 1922 (Address) 1307 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glendy Burn	11/29 1922
20 UNDERTAKER Philip Lemmy	ADDRESS 2016 Aisquith

N. B.—WRITE PLAINLY, WITH PENCIL OR PEN AND INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69579

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69579

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1805 Alice Anna St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Biel

(Residence in Baltimore: No. 1805 Alice Anna St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: About 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15-

Filed NOV 29 1922 192.. Registrar.

ROBERT R. KRAUTER, Burial Permit Clerk.

T.D.699 - MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 20th (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown

(Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. T. Biddison M. D. (Coroner)

Nov 27 1922 (Address) Patter Bldg

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal.

Died Home

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. 192..

20-UNDERTAKER. ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

374

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69580 D69580

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Miles

(a) RESIDENCE NO. 324 N. Bruce St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Typewriting is preferable. Every question must be answered. Data for information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Municipal Hospital Records.

(Address)

15 Filed ....., 19 .....

NOV 29 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

19701

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 26 19 22

17

I HEREBY CERTIFY, That I attended deceased from November 14, 19 22, to November 26 19 22,

that I last saw him alive on November 25 19 22,

and that death occurred, on the date stated above, at 4:00 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

2 (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. - N.P.N. Phth.

(Signed) Clyde M. Reid, M. D.

11/27/19 22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

NOV 29 1922

D69581

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69581

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE, (No. Sheldens Ship yard St., Kenwood Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Doka

(Residence in Baltimore: No. ——— St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Unknown

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: about 29 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman on
(b) General nature of industry, business, or establishment in which employed (or employer): Ferry Atkins Phila, Pa

9-BIRTHPLACE, (State or Country): Unknown

PARENTS:

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15-

Filed NOV 23 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 21st 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy and inquiry find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

Nov 27 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. ..... 19....

20-UNDERTAKER. ADDRESS

NOV 23 1922

10700 MORGUE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D69582 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 D69582

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 N. ~~Caroline~~ Bond ST.; 7 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Jones

(Residence in Baltimore: No. 903 N Bond St.; 50 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown (Month) ....., 1 (Day) ..... (Year)

7-AGE 66 apprx. yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establisbment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Snowhill Md

PARENTS.

10-NAME OF FATHER, Abraham Armstrong

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER ~~Maria Armstrong~~ Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Jones

(Address) 903 N. Bond St.

15- NOV 29 1922 191..... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 27, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1921, to Nov 27 1922, that I saw h[illegible] alive on Nov 27 1922, and that death occurred, on the date stated above, at 11 30P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) ..... yrs. couple mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. H. Jenny M. D.

11/29, 1922 (Address) 1[illegible] E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, Nov. 29, 1922

20-UNDERTAKER Mrs J. G. Locks ADDRESS 1302 Jefferson

Spec.—1-10-21—M&T—1500 Bks.

15 9 8 15
~~D69583~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69583

CERTIFICATE OF DEATH.

40

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 15 WARD)

2-FULL NAME Ursula Waidner.

(a) RESIDENCE NO. 2023 Clifton Ave City ST., 7 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? [illegible] yrs. [illegible] mos. [illegible] ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of George Waidner (Husband)

6 DATE OF BIRTH (month, day, and year) April 16, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	42	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress 070

(b) General nature of industry, business, or establishment in which employed (or employer) (")

(c) Name of employer (")

9 BIRTHPLACE (city or town) (") (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Catherine Astfalk. (")

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Johns Hopkins Hospital. Records (Address)

15 Filed NOV 29 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1922, to Nov. 27, 1922, that I last saw her alive on Nov. 27, 1922, and that death occurred, on the date stated above, at 5-30 P. m. A. m.

The CAUSE OF DEATH* was as follows:

Post-operative shock,
Cause not known.

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary) Pernicious Anemia for [illegible] (duration) 7 yrs. ... mos. [illegible] ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Nov. 23-22

Was there an autopsy? no

What test confirmed diagnosis? None.

(Signed) Carl H. Mattfeldt, M. D.

, 19 (Address) The Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. | DATE OF BURIAL Nov 28 1922

20 UNDERTAKER Geo. Leinbach & Son | ADDRESS Baltimore

N. B.—WRITE PLAINLY, WITH CARBON PENCIL. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

James P Byrne

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69584

CERTIFICATE OF DEATH.

4 90

D69584 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 728 W Lexington St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James P. Byrne

(Residence in Baltimore: No. 728 W Lexington St.; yrs. 44 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Don't Know 1.....
(Month) (Day) (Year)

7-AGE. 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balt Co

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Seale

(Address) Lexington Balto

15- FILED NOV 29 1922. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 24 192.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Heart disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

..... 192.... (Address) .....

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral	Nov 29th 192

20-UNDERTAKER.	ADDRESS
E. E. Jones	111 S Gilmor St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If under one year, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Chalmers N. Davis

Spec.—1-10-21—M&T—1500 Blks.

D69585

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69585

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

CITY OF BALTIMORE: (No. FORT MCHENRY, BALTO., MD. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME DAVIS, Chalmers N.

(a) RESIDENCE No. 21 Madison Ave., Hagerstown, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. — How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer "

9 BIRTHPLACE (city or town) -- (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Jerry M. Davis

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) "

14 Informant Hospital Records

(Address) Fort McHenry, Baltimore, Md.

15 NOV 29 1922 ROBERT R. KRAUTER Registrar

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 28 1922.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1922 to November 28, 1922, that I last saw h im alive on November 28, 1922, and that death occurred, on the date stated above, at 7:05 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic, Far Advanced and Active.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Hemoptysis

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Wm Menzies, M. D.

Surgeon (R)

11/29. 1922 (Address) Fort McHenry, Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clear Spring Washington Co. Md.

DATE OF BURIAL 11/27 1922

20 UNDERTAKER A. Zimmerman Bro

ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH CARBON PENCIL. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69586

CERTIFICATE OF DEATH.

X 135

#98'89.

(D69586

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST., 9 WARD)

2-FULL NAME Mrs. James Dorsey.

(a) RESIDENCE NO. Sykesville, Maryland WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~): Eleanor Dorsey (wife),

6 DATE OF BIRTH (month, day, and year) Feb. 13, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	63.	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer): (") 86

(c) Name of employer: (")

9 BIRTHPLACE (city or town) (State or country): (") Maryland

PARENTS

10 NAME OF FATHER: Augustus Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? ?

12 MAIDEN NAME OF MOTHER: ? Thomas.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Md.

14 Informant (Address): Johns Hopkins Hospital Records

15 NOV 29 1922 Filed, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1922. to Nov. 29, 1922.

that I last saw him alive on Nov. 29, 1922,

and that death occurred, on the date stated above, at 4:44 A m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) uremia

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Eugene C. Shaw, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catonsville, Md. Trinity Cemetery

DATE OF BURIAL Dec 2 1922

20 UNDERTAKER: C. M. Metz.

ADDRESS Winfield, Md.

N. B.—WRITE PLAINLY, with ordinary pen and ink. All items should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69587

CERTIFICATE OF DEATH.

139 D69587

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 112 (Street) S. Stricker ST.; (Ward) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Clara Jane Brady

(a) RESIDENCE. No. 112 S. Stricker ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 92 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Martin Brady

6 DATE OF BIRTH (month, day, and year) Feb 4-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Taking care of home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Richard Frezise

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary A. Hilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Martin Brady (Address) 112 S. Stricker St.

15 Filed NOV 29 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1922, to Nov 28, 1922, that I last saw her alive on Nov 27, 1922, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) — yrs. — mos. 2½ ds.

CONTRIBUTORY (Secondary) Peritonitis comp inoperable Fibroid tumor of uterus 3 Weeks

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Phillips M. D.

, 19 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec. 1. 1922
20 UNDERTAKER	ADDRESS
John O. Mitchell	120 W. Fayette

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69588

CERTIFICATE OF DEATH.

129 **D69588**

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hosp ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Morhiser

(a) RESIDENCE NO. 102 Augusta Ave ST. Irvington CITY

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced (or) WIFE of Harvey E. Morhiser

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	63	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House duties

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER John Norwood

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Harris

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Capt Harvey E. Morhiser

(Address) 102 Augusta Ave

15 NOV 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/27/22

17 I HEREBY CERTIFY, That I attended deceased from 11/5/22, 19..., to 11/27/22, 19...,

that I last saw her alive on 11/27/22, 19...

and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows: -

Arteria Sclerosis & Hypertension

Chronic Nephritis

Chronic Myocarditis

with Cardiac Hypertrophy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) H O Harper, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 30 1922

20 UNDERTAKER John B. Gallagher

ADDRESS 1201 W. Fayette

D69589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69589

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital, Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Frank D. Stumpf.

(Residence in Baltimore: No. Camp Meade, Md. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male.	White.	Married

6-DATE OF BIRTH. April 29th. 1870. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
51 yrs. 6 mos. 29 ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Foreman,
(b) General nature of industry, business, or establishment in which employed (or employer). Ammunition Co.

9-BIRTHPLACE, (State or Country). Boston, Mass.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna M. Stumpf. (wife)

(Address) New Brunswick, N.J.

15- Robert P. Harrison,

Filed ..... 192.....

NOV 29 1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 27th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Automobile accident.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

Nov, 29 192 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?
Linthicum Heights. Nov, 27th. 1922.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Boston Mass — DATE OF BURIAL. 11/29/22 19...

20-UNDERTAKER. Chas F. Coombs Son — ADDRESS 118 W Mt Royal

N.B.—Every item of information should be carefully supplied. The state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. Age should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69590 HEALTH DEPARTMENT—CITY OF BALTIMORE **D69590**

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 706 N. Appleton St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Muir

(Residence in Baltimore: No. 706 N. Appleton St. St.; 64 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): widower

6-DATE OF BIRTH: April 27, 1858 (Month) (Day) (Year)

7-AGE: 64 yrs. 7 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer): (clerk)

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS:

10-NAME OF FATHER: Jas. M. Muir

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Eliz. Gurman

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliz. Gurman

(Address) 706 N. Appleton St.

15. Filed NOV 29 1922 Robert P. Carlson, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 28 (Month) (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) 17 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Hennessy M. D. (Coroner.)

Nov 29, 1922 (Address) 7 E Lexington St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Greenmount Park — DATE OF BURIAL: Nov 30 1922

20-UNDERTAKER: Wm Carle — ADDRESS: 502 E Baltimore

NOV 29 1922

Spec.—1-10-21—M&T—1500 Bks.

Richard en - 112 N 20th W ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69591

CERTIFICATE OF DEATH.

122-002

D69591

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 102 E 21st (St.) 17 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Selma Hollidor

(a) RESIDENCE NO. 102 E 21st St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sml L Kmm

6 DATE OF BIRTH (month, day, and year) Feb 10 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Wm Pelete

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sml L Kmm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sml L Kmm

14 Informant Mrs Celia M. Smith (Address) 102 E 21st St.

15 Robert F. [illegible] Registrar

NOV 29 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1922, to Nov 28, 1922, that I last saw h[illegible] alive on Nov 28, 1922, and that death occurred, on the date stated above, at 11.45 a m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility & Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lee Richardson M. D.

Nov 29 1922 (Address) 1124 N. 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Nat. Woodlawn	Nov 30 1922
20 UNDERTAKER	ADDRESS
H. Lee Cook	502 E. Fayette

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D69592

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69592

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 N. Carey ST., 18 WARD)

2-FULL NAME Mason Beecher

(a) RESIDENCE NO. 421 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4-1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Clear Spring Md

PARENTS

10 NAME OF FATHER Wm Beecher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Maria Guthrie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs. B. Suter

(Address) 3433 Woodlawn Ave

15 Filed Nov 29 1922 Robert P. Carraban, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1922, to Nov. 29, 1922, that I last saw h alive on Nov 29, 1922, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Convulsions

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A Evans, M. D.

, 19 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec. 1 1922
20 UNDERTAKER Harry W. Ehlen	ADDRESS 944 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 29 1922

Spec.—1-10-21—M&T—1500 Blks.

D69593

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69593

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1032 Gilis Court ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie May Nelson

(a) RESIDENCE NO. 1032 Gilis Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 20-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Richard Nelson

11 BIRTHPLACE OF FATHER (city or town) Gilbert Co (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne Rowley

13 BIRTHPLACE OF MOTHER (city or town) Gilbert Co (State or country) Ireland

14 Informant Richard Nelson (father)
(Address) 1032 Gilis Court

15 Filed NOV 30 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27 1922

17 I HEREBY CERTIFY, That I attended deceased from 11-25, 1922, to 11-27, 1922, that I last saw h[illegible] alive on 11-27, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(a) Bronchial Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] M. D.

, 19 (Address) 1618 Fawn Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Nov 30 1922

20 UNDERTAKER David Easton ADDRESS 916 Ca Ave

NOTE.—Certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D69594

D69594

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2924 Huntington Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy M. Smith.

(a) RESIDENCE. NO. 2924 Huntington Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. Information should be carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Smith

6 DATE OF BIRTH (month, day, and year): June 25 1877

7 AGE — Years: 45 Months: 5 Days: 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Charles Harp.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Susan Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Chas Smith

(Address): 2924 Huntingdon Ave

15 Filed NOV 30 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 29 1922

17 I HEREBY CERTIFY, That I attended deceased from May 25th, 1922, to Nov 29, 1922, that I last saw her alive on Nov 29, 1922, and that death occurred, on the date stated above, at 1.50 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Samuel Miller, M. D.

19 (Address) 1506 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Dec 1 19

20 UNDERTAKER: A. S. Marshall

ADDRESS: 5537 Falls Rd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69595

CERTIFICATE OF DEATH.

159-002

D69595

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1013 S. Charles St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jack Miller.

(Residence in Baltimore: No. 1013 S. Charles St. St.; yrs. ---- mos. 2 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single.

6-DATE OF BIRTH. November 27th. 1922.
(Month) (Day) (Year)

7-AGE. ---- yrs. ---- mos. 2 ds.

If LESS than 1 day, ... hrs. or, ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. William Miller.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Julia Lang.

13-BIRTHPLACE OF MOTHER, (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Miller. (mother)

(Address) 1013 S. Charles St.

15- Filed NOV 30 1922 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 29th. 1922. 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Eisenhardt M. D.
(Coroner)

Nov. 29 192 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cemetery. DATE OF BURIAL. Nov. 30 1922

20-UNDERTAKER. John F. Denny ADDRESS 715 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69596

CERTIFICATE OF DEATH.

31

D69596

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 526 W Mulberry (St.) 14 (Ward)

2-FULL NAME James Samuel Boone

(a) RESIDENCE. (No.) 526 W Mulberry St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lula Boone

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE — Years: 49 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teamster

(b) General nature of industry, business, or establishment in which employed (or employer): Omnibus teams

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Griffith Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Richard Griffith Boone

(Address) 1307 Druid Hill Ave

15 Filed NOV 30 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1922, to Nov 27, 1922, that I last saw h— alive on Nov. 27, 1922, and that death occurred, on the date stated above, at 8 A, m.

The CAUSE OF DEATH* was as follows:

Pleurisy - DOUBLE

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Carcinoma Pancreatitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R. G. Armistead M. D.

(Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Nov 30 1922

20 UNDERTAKER: Samuel Hemsley — ADDRESS 578 N Bradd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tuberculosis

Spec.—1-10-21—M&T—1500 Bks.

D69597

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D69597

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (WARD) 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. S. Lewis

(a) RESIDENCE NO. 2804 Fox st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown ~~Not given~~

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years 51; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Wm. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Hannah Billingsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant (Address): Hospital Records

15 FILED NOV 30 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1922, to Nov. 27, 1922, that I last saw him alive on Nov. 27, 1922, and that death occurred, on the date stated above, at 10 A.M. m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Aneurysm

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) Francis L. Gadaglucca, M. D.

11-27-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount DATE OF BURIAL: NOV 30 1922

20 UNDERTAKER: Daniel J. Kennedy ADDRESS 578 N. Bond

IMPORTANT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D69598

D69598

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1419 Bunch St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Ackwood

(Residence in Baltimore: No. 1419 Bunch St.; 6 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, [illegible] (Month) (Day), 1838 (Year)

7-AGE 84 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer): Dry Goods

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Wm. Ackwood

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Barnes

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. R. Ackwood

(Address) 947 Druid Ave

15- NOV 30 1922 ROBERT R. KRAUTER, Registrar.

Filed ....., 191..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 29th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 14th 1922, to Nov. 29th 1922, that I saw h[illegible] alive on Nov. 29th 1922, and that death occurred, on the date stated above, at 8:00 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Infirmities of Age

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

11-29-, 1922, (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, D[illegible] Cem

DATE OF BURIAL, Dec. 2, 1922

20-UNDERTAKER Jas. J. Kennedy

ADDRESS 528 N. Biddle

N.B.—Every item of information should be carefully supplied. PLACE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168

Registered No. D69599

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 N. East Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel R. McVey

(Residence in Baltimore: No. 117 N. East Ave St.; 9 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: June 23rd (Month) (Day) 1888 (Year)

7-AGE: 34 yrs. 5 mos. 5 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: R.R. Fireman
(b) General nature of industry, business, or establishment in which employed (or employer): C&O

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: John McVey

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ada V. McVey

(Address) 117 N. East Ave

15- NOV 30 1922 Filed ..... 192.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 28 (Month) (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation by hanging — Suicide —

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. W. Horton M. D.

Nov 29 1922 (Address) Curtis Bay Coroner

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal.

Dated, Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Conowingo Md	12/1 1922
20-UNDERTAKER.	ADDRESS
Philip Hennig	2016 Orleans

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69600 HEALTH DEPARTMENT—CITY OF BALTIMORE **D69600**

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry M Snook

(a) RESIDENCE. NO..... Harpers Ferry W.Va ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Susie B Snook

6 DATE OF BIRTH (month, day, and year) Mar 16 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Railroad Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer 673

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Benjamin Snook

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Mary A. Jarman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Harry E. Snook Jr.

(Address) 1706 Linden Ave

15 Filed NOV 30 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

Via Booker - C/o Harry E Snook

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1922, to Nov 30, 1922, that I last saw him alive on Nov 30 1922, and that death occurred, on the date stated above, at 145 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J. Norwood Wilson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harpers Ferry W. Va	Dec 1 19 22
20 UNDERTAKER	ADDRESS
Wm Cook & Son	502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D69601

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69601

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1806 Lancaster ST., W WARD)

2-FULL NAME Anna M. Cody

(a) RESIDENCE NO. 1806 Lancaster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Married

If married, widowed, or divorced (or) WIFE of Pierce E. Cody

6 DATE OF BIRTH (month, day, and year) Feb 9 - 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	36	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Herman Schulz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kate Hassauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Pierce E. Cody

(Address) 1806 Lancaster

15 NOV 30 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1922, to Nov 29, 1922, that I last saw her alive on Nov 28, 1922, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) unknown. yrs. mos ds.

CONTRIBUTORY (Secondary) unknown.

(duration) unknown. yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Joseph L. Valentine M. D.

1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Land — DATE OF BURIAL Dec 2 1922

20 UNDERTAKER Wm Cook & Sons E Hauth — ADDRESS

N. B. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69602

D69602

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 St Monroe St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Freidlander

(Residence in Baltimore: No. 1722 St Monroe Street St.: 34 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) M

6-DATE OF BIRTH, (Month) Unknown (Day) , (Year) 1847

7-AGE, 75 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Morris Scheer

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Ettla

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Conrad Freidlander

(Address) 1722 St. Monroe St.

15- Filed NOV 30 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 30., (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 1922, to Nov. 30 1922, that I saw her alive on Nov. 29 1922 and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows: Myocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(Duration) yrs. mos. 3 ds.

(Signed) K. C. Metzler M. D.

Nov. 30., 1922 (Address) 1903 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rodeph Sholom — DATE OF BURIAL, 11/30., 1922

20-UNDERTAKER, Jack Lewis — ADDRESS 1439 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69603 — CERTIFICATE OF DEATH. — 57 — D69603

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Dukeland Av ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Florence B. Glendenning

(a) RESIDENCE NO. 1819 Dukeland Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 50 yrs. 2 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Wht	Married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Chas. H. Glendenning

6 DATE OF BIRTH (month, day, and year) Sept 8 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Rutter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Kate Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frances Mills Frederick Co Md

14 Informant Chas. H. Glendenning
(Address) 1819 Dukeland Ave

15 NOV 30 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29th 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1921, to Nov 29, 1922,
that I last saw her alive on Nov. 29, 1922,
and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Carbuncle on neck & Trap
Diabetic Coma

(duration) ... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Diabetic Nephritis

(duration) ... yrs. 16 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Ed Smith M. D.

Nov 1922 (Address) 1608 N Monroe Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Park Cemetery — DATE OF BURIAL Dec 2 1922

20 UNDERTAKER Wilbur W. Shriver — ADDRESS 1018 Edmondson Ave

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

69064
D69604

HEALTH DEPARTMENT—CITY OF BALTIMORE

69604
D69604

CERTIFICATE OF DEATH.

47

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 N Carrollton ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Lobby

(Residence in Baltimore: No. 1003 N. Carrollton ave. St.: (yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 6 (Day), 1859 (Year)

7-AGE, 63 yrs. 5 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Own

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Lewis Gleen

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Gertrude Richardson

(Address) 1003 N Carrollton Ave.

15-Filed NOV 30 1922, 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 28 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23 1922, to Nov. 28 1922, that I saw her alive on Nov. 27 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast.

(Duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Carey M. Hayes M. D.

Nov 30 1922 (Address) 1046 Penrose

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Danville Va

19-PLACE OF BURIAL OR REMOVAL, Danville Va. DATE OF BURIAL, Dec. 30, 1922

20-UNDERTAKER James A Lewis ADDRESS 203 Goodman

N. B.—Every item of information should be carefully supplied. NOTE should be taken of OCCUPATION in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Ella Bosley

D69605

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69605

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH 2120 Williams Ave

CITY OF BALTIMORE: (No. 2120 Fulton Ave ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Bosley

(a) RESIDENCE NO. 2120 Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (a) ~~HUSBAND of~~ (b) WIFE of the late Wm J. Bosley

6 DATE OF BIRTH (month, day, and year) March 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Madden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant William E. Bosley

(Address) 2120 Williams Ave

15 Filed DEC 1-1922 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1922, to Nov 29, 1922, that I last saw h~~e~~r alive on Nov 28, 1922, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. ! ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) James F. O'Donnell M. D.

11/30, 1922 (Address) 1774 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL DEC 1 1922

20 UNDERTAKER Harry H. Witzke — ADDRESS 1531 W Lombard

N. B. WHITE BLANKS. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69606

CERTIFICATE OF DEATH.

5 31

D69606

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Mc Elderry ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo N. Johnson

(Residence in Baltimore: No. 1216 Mc Elderry St.: ..... yrs., 7 mos. weeks ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) —

6-DATE OF BIRTH, Oct. (Month) 25 (Day), 1921 (Year).

7-AGE, 1 yrs. 1 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Montgomery Co. Md.

PARENTS.

10-NAME OF FATHER, Robert Johnson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Manola White

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Johnson (Father)

(Address) [redacted] Mc Elderry St.

15-

Filed DEC 1-1922 ROBT. R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 29 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/26 1922, to 11/29 1922, that I saw h[illegible] alive on 11/26 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

about

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. J. Young M. D.

11/29, 1922 (Address) 1429 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, 12/1/22, 1922

20-UNDERTAKER Jas. Inv. Skinner ADDRESS 1210 E. 22nd St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69607

CERTIFICATE OF DEATH.

159-002 D69607

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3817 Pleasant Pl ST.) 13 WARD)

2-FULL NAME Annabell Kilmon

(a) RESIDENCE NO. 3817 Pleasant Pl ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 25 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	✓	✓	31	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City (State or country)

PARENTS

10 NAME OF FATHER Thomas A Kilmon

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Armina Haron

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Thomas A Kilmon (Address) 3817 Pleasant Pl

15 DEC 1 - 1922 ROBERT N. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1922, to Nov. 30, 1922, that I last saw h[illegible] alive on Nov 30, 1922, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical symptoms

(Signed) C. F. Hughes M. D.

12/30, 1922 (Address) 320 Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden DATE OF BURIAL Dec 1 1922

20 UNDERTAKER Chenowith Son ADDRESS Chestnut

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69608

CERTIFICATE OF DEATH.

101-001

D69608

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3619½ Roland Ave ST., 13 WARD)

2-FULL NAME Fannie Mary Cromwell

(a) RESIDENCE NO. 3619½ Roland Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Cromwell,

6 DATE OF BIRTH (month, day, and year): May 24, 1851

7 AGE: Years 66 Months 6 Days 6 If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Dwyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliza Beach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Philadelphia Pa

14 Informant: Clemma Cromwell

(Address) 903 W 40th St

ROBERT N. KRAUTER,

15 Filed DEC 1 1922 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 19th, 1922, to Nov 29, 1922, that I last saw h[illegible] alive on Nov 29, 1922, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. —

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) A. D. Townsend M. D.

(Address) 3543 Chestnut Ave

Nov 30, 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: Dec 3 1922

20 UNDERTAKER: Cohenworth Lore & Chestnut Ave — ADDRESS

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69609

CERTIFICATE OF DEATH.

90 D69609

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Edgewale Road ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane McKenzie Robinson

(a) RESIDENCE NO. 207 Edgewale Road ST., 27 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 3 mos. 26 ds. How long in U. S., If of foreign birth? 77 yrs. 3 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alphonso Robinson

6 DATE OF BIRTH (month, day, and year) Aug-3-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Colvin McKenzie

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane (not known)

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mr. Harry E. Kerr (son) (Address) 207 Edgewale Road City

15 Filed DEC 1 1922, 19.. HOWARD N. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1922, to Nov. 29, 1922, that I last saw her alive on Nov. 20, 1922 and that death occurred, on the date stated above, at 3.00 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Acute Dilatation).

(duration) 5 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 10 yrs. + mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? none

(Signed) H. E. Wades, M. D.

Nov. 29. 1922 (Address) 3101 Clifton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL Dec-1-1922

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. If less than one year state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69610

CERTIFICATE OF DEATH.

100-001 D69610

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 Ridgewood Rd ST., 27 WARD)

2-FULL NAME Anna Clare Randolph

(a) RESIDENCE NO. 220 Ridgewood Rd ST., 27 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 84 yrs. 1 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Randolph

6 DATE OF BIRTH (month, day, and year) Oct-8-1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establiahment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Georgetown (State or country) D. C.

PARENTS

10 NAME OF FATHER James King

11 BIRTHPLACE OF FATHER (city or town) Georgetown (State or country) D. C.

12 MAIDEN NAME OF MOTHER Mary Slye

13 BIRTHPLACE OF MOTHER (city or town) Georgetown (State or country) D. C.

14 Informant Prof. Harold Randolph, son (Address) 222 Ridgewood Road

15 Filed DEC 1 1922 M. R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1922,

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1922, to Nov. 29, 1922, that I last saw h alive on Nov. 24, 1922 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral arterio sclerosis
Senile.
(duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia
(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. Hilton Porter, M. D.

11/29 1922 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cemetery — DATE OF BURIAL Dec 1 1922

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOOREN, Successor) — ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69611 CERTIFICATE OF DEATH. 27 161-002 **D69611**

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Craig

(a) RESIDENCE NO. 109 Woodburn Ave ST., 27 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? — yrs. — mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11/29/22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm Harrison Craig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Castle Shannon - Pa

12 MAIDEN NAME OF MOTHER Louise Hoyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lawson - Colorado

14 Informant W. H. Craig (Father) (Address) 109 Woodburn Av City

15 Filed DEC 1 1922, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/30/1922

17 I HEREBY CERTIFY, That I attended deceased from 11/29/22, 19 ..., to 11/30/22, 19 ...; that I last saw him alive on 11/29/22, 19 ...; and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Intracranial pressure

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hydrocephalus

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) G. F. Goff M. D.

19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Cemetery - Towson Md

DATE OF BURIAL Dec 2 1922

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODER, Successor)

ADDRESS 108 W. NORTH AVE

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69612

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001

D69612

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augusta Mohl

(Residence in Baltimore: No. 1602 Cole st St.; yrs. 45 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced.~~ (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. November 10 1830
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
87 yrs. mos. 16 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House work
(b) General nature of industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Conl Knorr

11-BIRTHPLACE OF FATHER, (State or Country) Germany

12-MAIDEN NAME OF MOTHER. Conl Knorr

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Clara Romaine

(Address) 1602 Cole Ave.

15. DEC 1-1922 1922

ROBERT R. KRAUTER
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 28 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Due to Gas Illuminating Gas Accident

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Senile Debility

(Duration) yrs. mos. ds.

(Signed) James W Fenton M. D.
(Coroner.)

Nov 30 1922. (Address) 701 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death yrs. mos. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

1602 Cole St

Former or usual residence 1602 Cole St

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Pauls Violet Hill	Dec 1 1922

20-UNDERTAKER Robt F Turner Son ADDRESS 1112 N Broadway

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146

D69613

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers of America Hospital ST. 1926 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Martin

(a) RESIDENCE. No. 523, 13th st. Highlandtown WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 31st 1884

7 AGE: Years 38 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Andrew J Frantz
(Address) 523 S 13th St.

15 DEC 1 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1922, to Nov 29, 1922, that I last saw her alive on Nov 29, 1922, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Puerperal Infection

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Peritonitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at her home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) Albert F. Conley, M. D.

, 19 (Address) Vol. of America Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: Dec 1 1922

20 UNDERTAKER: Bolt & Turner Inc

ADDRESS 1442 Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 llks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69614 100-001 D69614

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 N. Bond St ST.) 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Drake

(Residence in Baltimore: No. 415 N. Bond St St.; yrs., mos. 16 ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	C	—

6-DATE OF BIRTH, Nov. 13, 1922 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Johnson Drake

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Laura Parker

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Laura Drake

(Address) 415 N. Bond St.

15- Filed DEC 1-1922, 191... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11/ 29, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/29 1922, to 11/29 1922, that I saw h[illegible] alive on 11/28 1922, and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. ....mos. 16 ds.

CONTRIBUTORY (Secondary) —

(Duration) ....yrs. ....mos. ....ds.

(Signed) R. J. Young M. D.

11/29, 1922 (Address) 104 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Evergreen Cem.	Dec. 1, 1922
20-UNDERTAKER	ADDRESS
Wm J. S. Locks	1302 Jefferson St.

Spec.—1-10-21—M&T—1500 Bks.

D69615

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69615

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1169 Dexter ST. 21 WARD)

2-FULL NAME Mary Parker Musgrove

(a) RESIDENCE NO. 1169 (Usual place of abode) Dexter ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William D. Musgrove

6 DATE OF BIRTH (month, day, and year): Dec. 10, 1891

7 AGE — Years: 30 — Months: 11 — Days: 18 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Elkridge (State or country) Howard Co. Md

PARENTS

10 NAME OF FATHER: Joseph M. Tucker

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER: Anna L. Lindt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant: William D. Musgrove (Address) 1169 Dexter St

15 Filed DEC 1 - 1922 By ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-28 1922

17 I HEREBY CERTIFY, That I attended deceased from April, 1921, to Nov. 28, 1922, that I last saw her alive on Nov. 27, 1922, and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) ? yrs. 18 mos ds. to my knowledge

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Howard L. Folsom M.D.

19 (Address) 1325 E Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec / 1922

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Kozeminski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69616

D69616

90

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 Aliceanna ST., 2 WARD)

2-FULL NAME John Kozeminski

(a) RESIDENCE NO. 1922 Aliceanna ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 23 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Helen Kozeminski

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	50	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Sugar ref. 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Kozeminski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Helen Kozeminski
(Address) 1922 Aliceanna

15 Filed ROBERT R. KRAUTER, DEC 1 - 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/30 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1922, to Nov. 30, 1922.

that I last saw him alive on Nov. 30, 1922.

and that death occurred, on the date stated above, at 12 30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Aortic - Stenosis

? (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Acute Coronae Dilatation (duration) ... yrs. ... mos. 2 hours ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Irwin J. Kreuzer, M. D.

11/30, 1922 (Address) 1009 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	12/2 1922
UNDERTAKER Wm. Faulkner	ADDRESS 618 Eastern

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69617 HEALTH DEPARTMENT—CITY OF BALTIMORE D69617

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 N. Chapel ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Anton J. Knoll

(a) RESIDENCE. NO. 107 N. Chapel ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26/1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

845

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Knoll

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Kate Kapelan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Mrs John Knoll (Address) 144 N. Chapel

15 Filed DEC 1 - 1922 19 ROBT. R. KNAUER Burial Permit Clerk (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1922, to Nov. 29, 1922, that I last saw him alive on Nov. 29, 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pelletreau, M. D.

, 19 (Address) 817 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill Cem

DATE OF BURIAL: Dec. 4 1922

20 UNDERTAKER: Jos. J. Kerr

ADDRESS: 156 N. Luzerne Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69618

CERTIFICATE OF DEATH.

137 7+001

D69618 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3631 Elm Ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma M. Gibson

(a) RESIDENCE. NO. 3631 Elm Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: G. Glanville Gibson

6 DATE OF BIRTH (month, day, and year): Oct 19 1851

7 AGE — Years: 71 — Months: 1 — Days: 11 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City Md

PARENTS

10 NAME OF FATHER: Hugh A Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs G G Gibson

(Address) 3631 Elm Ave

15 Filed DEC 1 - 1922, 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1 1922 to Dec 1 1922, that I last saw h[er] alive on Nov. 30 1922, and that death occurred, on the date stated above, at 3.50A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

at Hypertension

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral hemorrhage

(duration) ? yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam.

(Signed) unsound M. D.

Dec 1, 1922 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Dec 4 22

20 UNDERTAKER: A S Marshall — ADDRESS: 3539 Fallsd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Walter J. Morris

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69619

CERTIFICATE OF DEATH.

D69619

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 27 Ward) 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter J. Morris

(Residence in Baltimore: No. 4748 York Road St.; yrs. 56 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: ..... 1..... (Month) (Day) (Year)

7-AGE: 56 yrs. 8 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Jno Morris

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Rebecca Thomas

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Morris

(Address) 4748 York Rd. City

15-

Filed DEC 1-1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 29 22 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Riley M. D. (Coroner)

Dec 1 192.. (Address) 16 E Fayette

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death....yrs. 2 mos. ....ds. In the State....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery DATE OF BURIAL Dec 2 1922

20-UNDERTAKER, W. J. Tickner & Son ADDRESS 1st & Northern Ave

Spec.—1-10-21 M&T 1500 Bks.

(See Letter attached) ✓

D69620 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D69620

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 400 E. 25th ST. 17th WARD)

2-FULL NAME. Isaac Gardner

(a) RESIDENCE NO. 400 E 25th St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susie Gardner

6 DATE OF BIRTH (month, day, and year): June 7th 1855

7 AGE: Years 63 Months 6 Days 22 If LESS than 1 day, hrs or min. 13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer: Md. Rail Way Co

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Isaac Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Susie Gardner

(Address) 400 E 25th St

15 Filed DEC 1 1922, 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 29th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 25th, 1922, to Nov 29th, 1922.

that I last saw h[illegible] alive on Nov. 29th, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) [illegible] M. D.

11/29/22 (Address) 401 E 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: Dec 1 1922

20 UNDERTAKER: [illegible]

ADDRESS: North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should take CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DR. GEO. W. MURGATROYD
401 E. 25TH STREET
PHONE HOMEWOOD 1582

OFFICE HOURS
8 TO 10 A
7 TO 8 P
SUNDAY 8 TO 10 A

BALTIMORE, Dec 17th 19

Health Department

Dear Sirs.

Will you kindly correct da
of birth on the death certificate of Frank
Gordler 400 E. 25th St. died Nov. 29th/22
The date of birth should be June 7th 185
age at death 63 yrs 5 mos. 22 da.
This correction is made so as not to
conflict with his insurance thanki
you for same

I am

Yours Respectfully

Geo W Murgatroyd M.D.

Spec.—1-10-21—M&T—1500 Bks.

D69621

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69621

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3022 Harford Ave. ST., 9 WARD)

2-FULL NAME Mary A. Gibson

(a) RESIDENCE NO. 3022 Harford Ave. ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James McC. Gibson

6 DATE OF BIRTH (month, day, and year) Feb. 11, 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City
(State or country) Md.

PARENTS

10 NAME OF FATHER John H. Booth

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary A. Itson

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Germany

14
Informant James McC. Gibson
(Address) 3022 Harford Ave.

15
Filed ... 19 ... Registrar
DEC 1-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29th 1922

17
I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1922, to Nov. 29, 1922, that I last saw her alive on Nov 29th 1922 and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robt. J. Kirk, M. D.

4/30 1922 (Address) 3126 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Dec. 2 1922

20 UNDERTAKER Wm. L. Black ADDRESS 927 N Broadway

N. B. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69622

CERTIFICATE OF DEATH.

Registered No. C 187-007 D69622

1-PLACE OF DEATH City of BALTIMORE: (No. Bay View Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irving M. Bond

(Residence in Baltimore: No. 1870 N. Bond St.; yrs. 43 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: May (Month) 6th (Day) 1879 (Year)

7-AGE: 43 yrs. 6 mos. 23 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Pa. R.R. (b) General nature of industry, business, or establishment in which employed (or employer): Watchman

9-BIRTHPLACE, (State or Country): Md

PARENTS:

10-NAME OF FATHER: Wm B. Bond

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Anna L Dewell

13-BIRTHPLACE OF MOTHER, (State or Country): Harford Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna L. Bond

(Address) 1870 N. Bond St.

15- Filed DEC 1-1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 29th (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows: Right arm almost severed by Circular Saw - Lost Considerable blood & died from Shock (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accident (Duration) yrs. mos. ds.

(Signed) Chas. B. Horton M. D. (Coroner.)

Nov 30 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Balto. Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Abingdon Harford Co. DATE OF BURIAL: Dec 2 1922

20-UNDERTAKER: Chas. D. Whitelaw ADDRESS 120 N. Bond St.

N. B.—Every item of information should be given as fully as possible, and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Claudia A. Phenis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69623

1-PLACE OF DEATH

CERTIFICATE OF DEATH. 1290

D69623

Registered No. C.....

City of BALTIMORE: (No. 419 N. Mount St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Claudia A. Phenis

(Residence in Baltimore: No. Alla-mont Av. Catonsville St.; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH: June 21 1862 (Month) (Day) (Year)

7-AGE: 60 yrs. 5 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House duties
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE. (State or Country). Ky.

PARENTS

10-NAME OF FATHER. Isaac Lowe

11-BIRTHPLACE OF FATHER. (State or Country). Ky.

12-MAIDEN NAME OF MOTHER. Vanie Devitt

12-BIRTHPLACE OF MOTHER. (State or Country). Ky.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ada. Draper
Nancy Reed

(Address)

15- Filed DEC 1 - 1922 ROBERT R. KRAUTER, (Registrar.)

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov 30 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. heart

Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner.) M. D.

Dec 2 192 (Address) 1639 Bradley

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL. Dec 2 192

20-UNDERTAKER. John Mitchell ADDRESS 120 W. Fayette St

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69624

CERTIFICATE OF DEATH.

166 D69624

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Edna Morris

(Residence in Baltimore: No. 1323 W. Fayett St.; yrs. 3 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	Married

6-DATE OF BIRTH, April (Month) 18 (Day) 1901 (Year)

7-AGE, 21 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)..... Restaurant

9-BIRTHPLACE, (State or Country), Wells Pa

PARENTS.

10-NAME OF FATHER, Phillip Duncan

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Eva Cooper

13-BIRTHPLACE OF MOTHER, (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Walter Myers

(Address)..... Bel Air Md

15- Filed DEC 1-1922 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 30 (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an June inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury
Poisoning Self administered
Suicide

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Acute nephritis

(Duration) yrs. mos. 4 ds.

(Signed) James M. Fenton M. D.
(Coroner.)

Dec 1 192 2 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents)
At place of death yrs. mos. 11 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1323 W Fayett St

Former or usual residence " " "

19-PLACE OF BURIAL or REMOVAL, Statesville Pa DATE OF BURIAL, Dec 3 19 22

20-UNDERTAKER, John O. Mitchell ADDRESS 1201 W. Fayette

N. B.—Every item of information should be carefully supplied. Note state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

D69625

D69625

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

CITY OF BALTIMORE: (No. 456 E. Cross St. ST., 24th WARD)

2-FULL NAME Dollie Kensel

(a) RESIDENCE NO. 456 E. Cross ST., 24th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

5a If married, widowed, or divorced (HUSBAND of) (WIFE of) John Kensel

6 DATE OF BIRTH (month, day, and year) Dec 30, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	48	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Church Creek (State or country) Dorchester Co., Maryland

PARENTS

10 NAME OF FATHER Edward Spencer

11 BIRTHPLACE OF FATHER (city or town) Church Creek (State or country) Dor. Co. Maryland

12 MAIDEN NAME OF MOTHER Elizabeth McKinns

13 BIRTHPLACE OF MOTHER (city or town) Church Creek, (State or country) Dor. Co., Maryland

14 Informant Sister Mrs. Mary E. Richardson

(Address) 1122 Battery Ave

15 Filed DEC 1 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 30, 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 26, 1922 to Nov 30, 1922.

that I last saw her alive on Nov 30, 1922,

and that death occurred, on the date stated above, at 4 00 A.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 6 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis

(Signed) Henry F. Buettner M. D.

, 19 (Address) 1273 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 12/2 1922

20 UNDERTAKER L. Frew McCully

ADDRESS 130 E. Fort.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69626

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 537 N. Mount St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Dixon

(Residence in Baltimore: No. 537 N. Mount St.; 45 yrs. 5 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed or Divorced, (Write the word): Widow

6-DATE OF BIRTH: June (Month) 3 (Day) 1877 (Year)

7-AGE: 45 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Maid
(b) General nature of Industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country): Md.

PARENTS

10-NAME OF FATHER: Isaac Tubman

11-BIRTHPLACE OF FATHER, (State or Country): Conn.

12-MAIDEN NAME OF MOTHER: Fanny Conner

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola Dixon

(Address) 532 N. Mount St.

15- DEC 1-1922 ROBT. S. KRAUTER Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 29 (Day) 1922 (Year)

I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage,

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertension

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hamilton M. D.
(Coroner.)

Nov. 29 1922 (Address) 2012 Eutaw Place

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

17-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

18-PLACE OF BURIAL OR REMOVAL: Laurel Cem. DATE OF BURIAL: Dec 2nd 1922

19-UNDERTAKER: A. Jones ADDRESS 1115 E. Fulton

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Guoff.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69627

CERTIFICATE OF DEATH.

6 74-001

D69627

Registered No. C.....

1-PLACE OF DEATH Pronounced Dead at

City of BALTIMORE: (No. Franklin Square Hospital St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Jeroff

(Residence in Baltimore: No. 54 Dunham St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	Married

6-DATE OF BIRTH. — — 1871
(Month) (Day) (Year)

7-AGE. 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home 834

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Carl Young

11-BIRTHPLACE OF FATHER. (State or Country). England

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). (/

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jeroff

(Address) 54 Dunham St.

15- Filed DEC 1-1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. (Month) 30 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Autopsy

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 1 yrs. mos. ds.

(Signed) James M. Fenton M. D.
(Coroner.)

Dec 1 1922 (Address) 700 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oakland — DATE OF BURIAL, Dec 4 1922

20-UNDERTAKER Lou Cook — ADDRESS 504 E Monument

N. B.—Every item of information should be carefully considered, and be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69628

CERTIFICATE OF DEATH.

D69628

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 122 Scott St. (Ward) 18

2-FULL NAME Lund H. Bloomer

(a) RESIDENCE. No. 122 Scott St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary L. Bloomer

6 DATE OF BIRTH (month, day, and year): April 25-1856

7 AGE: Years 66 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rullo Md.

PARENTS

10 NAME OF FATHER: Jos. H. Bloomer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: F. Boisen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mary L. Bloomer 122 Scott St.

15 Filed DEC 1-1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 29. 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25., 1922, to Nov. 29., 1922, that I last saw h[illegible] alive on Nov. 28., 1922, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Urine Analysis.

(Signed) Thos. Jenkins, M. D.

11/29, 1922 (Address) 888 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: 12/2 1922

20 UNDERTAKER: W. M. Cook ADDRESS: 502 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Baton 988 W. Lombard

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69629

CERTIFICATE OF DEATH.

100-001

D69629

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Gough ST., V WARD)

2-FULL NAME Mildred C. Rippeyer

(a) RESIDENCE NO. 1907 Gough St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31-1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Julius Rippeyer

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Florence Kimble

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Julius Rippeyer
(Address) 1907 Gough St

15 DEC 1-1922 ROBERT R. KRAUTER, Registrar
Special Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 - 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 19.. to Nov 30, 19 22,
that I last saw her alive on Nov 29, 19 22,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

19 ..... (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: Dec 2 1922

20 UNDERTAKER — ADDRESS: Wm Cook 502 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery:* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"): *Typhoid fever* (never report "Typhoid pneumonia"): *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69630

CERTIFICATE OF DEATH.

D69630

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 E. Lombard ST., 3 WARD)

2-FULL NAME Sarah Leah Cohn

(a) RESIDENCE NO. 802 E. Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cohen

6 DATE OF BIRTH (month, day, and year) Cohen

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1439 E Baltimore St.

15 Filed ..... 19 .....

DEC 1 - 1922 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to Nov 30, 1922.

that I last saw h[illegible] alive on Nov 30, 1922,

and that death occurred, on the date stated above, at 7:20 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. 1 mos. 1st ds.

CONTRIBUTORY (Secondary) Carcinoma Liver.

(duration) yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? 802 E Lombard St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Adler M.D.

12/1/22 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sinai Memorial Park

DATE OF BURIAL 12-1 1922

20 UNDERTAKER Act Levin

ADDRESS 1439 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. Fractions should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69631

CERTIFICATE OF DEATH.

D69631

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Saratoga ST.: 18 74-00 WARD)

2-FULL NAME Eliza Wheeler

(a) RESIDENCE. NO. 1120 Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 8 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard H. Wheeler

6 DATE OF BIRTH (month, day, and year): 3-10-1853

7 AGE: Years 69 Months 8 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(h) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS
10 NAME OF FATHER: Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Richard H. Wheeler 1120 W. Saratoga

15 Filed DEC 1 - 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1922, to Nov 29, 1922, that I last saw h[er] alive on Nov 29, 1922, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard M. D.

12/1, 1922 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Elm

DATE OF BURIAL: 12-1-1922

20 UNDERTAKER: Sam'l H. Chase & Son

ADDRESS 1400 Mosher

mation should be carefully supplied. Attention is directed to the law requiring that a CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69632

CERTIFICATE OF DEATH.

D69632

4 51 V

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Tyson

(a) RESIDENCE NO. 234 N. Pine St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	34	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Tyson

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Harriet Hubbard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Municipal Hospital Records.
(Address)

15 Filed DEC 1 - 1922, 19 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 27 1922

17

I HEREBY CERTIFY, That I attended deceased from November 16 1922, to November 27 1922, that I last saw her alive on November 26, 1922, and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Ulcerative vegetative endocarditis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Aut.

(Signed) Clyde McNeill, M. D.

11/28/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 12-1 1922

20 UNDERTAKER Jno. H. Chase Son

ADDRESS 4705 Wabash

mation should be carefully supplied. AGE should be stated EXACTLY. If UNKNOWN, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

109847 D69633

1-PLACE OF DEATH D69633

CERTIFICATE OF DEATH.

111-09 D69633

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST., 17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claude Mitchell

(a) RESIDENCE NO. 206 N. Ware St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elizabeth Mitchell

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Johns Hopkins Hospital

(Address) [illegible]

Filed DEC 1-1922, 19 Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14th, 1922, to Nov. 28th, 1922, that I last saw him alive on Nov. 28th, 1922, and that death occurred, on the date stated above, at 3:33 P. m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer

Lobar Lobular Exudative Pertussis

Bronchopneumonia

Ulcer for (duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 23/22

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) The Resident, M.D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Dec 1 19 22

20 UNDERTAKER Samuel Kemsley

ADDRESS Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. Informants should know CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69634

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69634

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Sch. Joseph's Hosp St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Elizabeth Blume

(Residence in Baltimore: No. 1401 N. Washington St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Child

6-DATE OF BIRTH. Dec (Month) 31 (Day) 1915 (Year)

7-AGE. 6 yrs. 10 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, John E Blume

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Myrtle M. Chandler

13-BIRTHPLACE OF MOTHER, (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John E. Blume

(Address) 1401 N. Wash.

15- DEC 1-1922 Filed 192 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 29 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Crushed Skull - Fracture
Automobile Accident

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. S. Patterson M. D. (Coroner.)

12-1 192 2 (Address) 508 E Northern

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore	Dec 2 1922
20-UNDERTAKER.	ADDRESS
Zickler & Zickler	1739 Eager st

N. B.—Every item of the above must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D69635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D69635

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 708 Ensor St

CITY OF BALTIMORE: (No. Christ's Institution Hospital ST., 7 WARD)

2-FULL NAME Junius Matthews

(a) RESIDENCE No. 1709 Cario St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27, 1884

7 AGE 38 Years Months 3 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Handay Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Louisa Saunders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant George Matthews

(Address) 6E. Lexington ROBERT R. KRAUTER

Filed DEC 1 - 1922 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 - 1922

17 I HEREBY CERTIFY, That I attended deceased from November 18, 1922 to November 30, 1922.

that I last saw him alive on November 30, 1922.

and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Dropsy + Bright Disease (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Dropsy + Bright Disease (duration) yrs. 3 mos. 4 ds.

18 Where was disease contracted if not at place of death? 1709 Carlo St Baltimore Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. H. W. Kennard M. D.

11-30 1922 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem'y — DATE OF BURIAL 12-2 1922

20 UNDERTAKER George H. Holland — ADDRESS 1661 Druid Hill Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Pulmonary Tuberculosis

Spec.—1-10-21—M&T—1500 Bks.

D69636

HEALTH DEPARTMENT—CITY OF BALTIMORE

36-001 D69636

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 326 - 22½ ST., 17 WARD)

2-FULL NAME Frank Isaacs

(a) RESIDENCE NO. 326 22½ St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar - 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Junk works

(c) Name of employer Not Employed for 3 Years

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Louisa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Sarah Isaacs

(Address) 326 22½ St.

15 DEC 1-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Feby, 1922, to Nov. 1922,

that I last saw him alive on Nov 25, 1922,

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Empyl

Duration and Profuse

of Lung Tract

(duration) 25 yrs. mos ds.

CONTRIBUTORY (Secondary) Deaf Head Influenza

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of work

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Gen

(Signed) Ballard K Smith, M. D.

, 19 (Address) 709 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Dec 1 1922

20 UNDERTAKER Mrs R. A. Elliott

ADDRESS 1720 Eastlander

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69637

CERTIFICATE OF DEATH. 100-001

D69637

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST.: W. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Pierce, Jr.

(a) RESIDENCE. NO. Whitehall, Md. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) Nov 6, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sept.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Pierce

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va.

12 MAIDEN NAME OF MOTHER Charlotte Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Hospital Records. (Address)

15 DEC 1-1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8th 1922 to Nov. 30 1922

that I last saw him alive on Nov 30 1922

and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Primary

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Operation for Hair Lip (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Univ. Hospital.

Did an operation precede death? Yes Date of Nov 10, 1922

Was there an autopsy? ———

What test confirmed diagnosis? Clinical Findings

(Signed) Kenneth B Jones, M. D.

Nov 30 1922 (Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodbury Cemetery	Dec 1 1922
20 UNDERTAKER P. Mackenzie Son	ADDRESS White Hall, Md.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69638

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69638

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal tuberculosis hospital ST., 11 WARD)

2-FULL NAME Walter Hughes

(a) RESIDENCE NO. 1219 McCulloh st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Groom

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Jackson Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Elizabeth Saunders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address) Robert P. Harrison. JOHNS HOPKINS HOSPITAL

DEC 1 1922 Filed Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 26, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1922, to Nov. 26, 1922, that I last saw him alive on Nov. 26, 1922, and that death occurred, on the date stated above, at 8.40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Syphilis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Padgett M. D.

11-27-22, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL DEC 1 19

ADDRESS

20 UNDERTAKER

Commissioner Health,

mation should be carefully supplied. AGE should be stated EXACTLY. Prevention CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D69639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D69639

1-PLACE OF DEATH Bay View Hosp. REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Eastern Ave. WARD) 3

2-FULL NAME John Fanahan

(a) RESIDENCE No. 3275 Carline ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Frank Lanahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER — McDermott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Municipal Hosp. Reads. JOHNS HOPKINS HOSPITAL

15 Dec 1 1922, 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-27 1922

17 I HEREBY CERTIFY, That I attended deceased from 11-13, 1922, to 11-27, 1922, that I last saw him alive on 11-27, 1922, and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus Causing Complete Obstruction of Pylorus

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Post Operative Shock

(duration) ..... yrs. ..... mos. 3 hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-27-22

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Richardson Jones, M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner Health,

Per. Wm. H. WOOBALL.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 1-1922

Spec.—1-10-21—M&T—1500 Bks.

D69640

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D69640

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE (No. 26 ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs D. Smith

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1857?

7 AGE: Years 65? Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): 887

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do,

14 Informant (Address): Bay View Hospital Balto. Md.

15 Filed 1922 Robert P. Harbison, Registrar

Burial Permit Filed 1978

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1922 to Nov. 27, 1922

that I last saw him alive on Nov. 26, 1922

and that death occurred, on the date stated above, at 4.40 a.m.

The CAUSE OF DEATH* was as follows:

Acute Anaesthesia

(duration) yr. mos. ds.

CONTRIBUTORY (Secondary) General Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Autopsy

(Signed) N. F. Dennis M. D.

12/1/22 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL Department of Pathology

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—1-10-21—M&T—1500 Bks.

D69641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D69641

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 N. Carey ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary G. Byrne

(a) RESIDENCE NO. 824 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 12th 1859

7 AGE: Years 63 Months 5 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0 10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pa

PARENTS

10 NAME OF FATHER Walter J Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Winifred Dyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant Mrs Sarah Byrne

(Address) 824 N. Carey St

15 Robert P. Garrison, Registrar

1-1922 d ..... 19 ..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 19 22

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23rd, 1922 to Nov 30, 1922, that I last saw her alive on Nov 29th, 1922, and that death occurred, on the date stated above, at 12.45 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 10 yrs. — mos — ds.

CONTRIBUTORY (Secondary) — —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Fielding F. Guilleman, M. D.

, 19 (Address) 1227 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Dec 1922

20 UNDERTAKER: Geo M. Fritz & Son

ADDRESS: 511 N. Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN also, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D69642 HEALTH DEPARTMENT—CITY OF BALTIMORE D69642

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3304 Fait Ave. ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry G. Schneider

(a) RESIDENCE. No. 3304 Fait Ave. ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Carl H. Schneider

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary G. Duer

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Carl H. Schneider (Address) 3304 Fait Ave (Father.)

15 Received , 19 Registrar

Burial Permit Clerk

C 1-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1922, to Nov. 29, 1922, that I last saw h[illegible] alive on Nov. 29, 1922 and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3-4 ds.

CONTRIBUTORY (Secondary) Convulsions (Terminal)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Henry C. Bailey, M. D.

(Address) 23 W. Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem.	Dec. 3 1922
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69643

D69643

CERTIFICATE OF DEATH.

48

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3816 Foster Ave ST.: 76 WARD)

2-FULL NAME Charles C. Fern

(a) RESIDENCE. No. 3816 Foster Ave ST., 76 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 5 - 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Musician

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Loring Fern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Barbara Armbrug

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Barbara Fern (Mother)
(Address) 3816 Foster Ave, Robert P. Barbara,

15 1922 ..... 19 ..... Registrar

Burial Permit Clerk

mation should be carefully supplied. ALL spaces must be filled. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

1-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 - 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1921, to Nov 29, 1922, that I last saw him alive on Nov 29, 1922, and that death occurred, on the date stated above, at 4.10 a.m.

The CAUSE OF DEATH* was as follows:

Multiple Sarcoma

(duration) yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Section

(Signed) Geo Clinton Bladel, M. D.

(Address) 1413 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Dec. 1 1922
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 N. Gay St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69644

CERTIFICATE OF DEATH.

9 101-001

D69644

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1925 Oak Hill Avenue ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Bosley

(a) RESIDENCE NO. 1925 Oak Hill Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Reed

6 DATE OF BIRTH (month, day, and year) April 20, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	49	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. Woolen Mill

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Bosley

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann M. Foos

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mr. Chas. L. Bosley

(Address) 317 E. Lafayette Avenue

15 Filed ..... 19 Robert P. Harrison, Registrar

1-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-29 1922

17 I HEREBY CERTIFY, That I attended deceased from 11-23, 1922, to 11-29, 1922, that I last saw h[illegible] alive on 11-29, 1922, and that death occurred, on the date stated above, at 11.50 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Bernard Watts, M. D.

11-30-22 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia

DATE OF BURIAL 12/1 19 22

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. Avoid abbreviations. CUPATION CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69645

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69645

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 N. Carey ST.: 16 WARD)

2-FULL NAME Addie V. Lawrence

(a) RESIDENCE. NO. 611 N. Carey ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 21-186[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5[illegible]	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ellicott City Md

PARENTS

10 NAME OF FATHER George W. Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Nellie Cooney

(Address) 611 N. Carey St

15 DEC 1 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1922, to Dec. 1, 1922,

that I last saw h[illegible] alive on Nov. 30 1922

and that death occurred, on the date stated above, at 2[illegible]35 9 m.

The CAUSE OF DEATH* was as follows:

Myocarditis - chronic
Nephritis -

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of lungs (Acute) dilatation of heart (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Leitz, M. D.

, 19 (Address) 2040 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Dec 4 1922
20 UNDERTAKER	ADDRESS
Geo J Smith 1002	Walbert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

C 1-1922

Spec.—1-10-21—M&T—1500 Bks.

15974 1-11-22 D69646

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69646

CERTIFICATE OF DEATH.

X 50

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE—(No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Eddie Hyman

(a) RESIDENCE NO. 6th + Boulevard St ST., WARD Huntington W. Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 25 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Hyman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Hanton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed 1-1922, 19 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec - 1 19-22

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1922, to Dec 1 - , 1922, that I last saw her alive on Dec. 1 - , 1922, and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Pt was operated on for tumor & husband died following operation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Yes Date of 12/1/22

Was there an autopsy?

What test confirmed diagnosis? X Ray.

(Signed) James E Kyle, M. D.

, 19 (Address) J H Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Huntington W. Va DATE OF BURIAL 12/1 19 22

20 UNDERTAKER Jack Lewis ADDRESS 1409 Eldred

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69647

CERTIFICATE OF DEATH.

D69647

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1947 Mt Patterson Park St.: 8 WARD)

2-FULL NAME Robert F. Jones

(a) RESIDENCE. No. 1947 Mt Patterson Park ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 20 1917

7 AGE: Years: Months: Days: 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Frances J. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Mary A. Plummer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Frances J. Jones

(Address): 1947 Mt Patterson Park

15 Filed DEC 1 1922 Robert F. HARTMAN, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): DEC 1-1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1922, to Dec 1-1922, that I last saw h alive on Nov 30/22, 19, and that death occurred, on the date stated above, at 10.45 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

over

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Erysipelas

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Haunt, M. D.

, 19 (Address) 1923 N Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Dec 4 1922

20 UNDERTAKER: William Cook

ADDRESS: 507 E North Ave.

Houck Cremation & Burial Co.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69648

CERTIFICATE OF DEATH.

100-001

D69648

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2344 Ivanna Ave ST., 15 WARD)

2-FULL NAME Robert W. Wagner

(a) RESIDENCE No. 5314 Hamlin Av. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Wh	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30/21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Frank L. Wagner

11 BIRTHPLACE OF FATHER (city or town) Balto Co.
(State or country)

12 MAIDEN NAME OF MOTHER Mary C. Myers

13 BIRTHPLACE OF MOTHER (city or town) Balto Co. Md.
(State or country)

14 Informant Frank L. Wagner
(Address) 5314 Hamlin Av

15 Filed ..... 19 ..... Registrar

Robert F. Leffler,
Burial Permit Clerk.

C 1 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1922, to Dec 1/22, 19 ., that I last saw him alive on Nov. 30, 1922, and that death occurred, on the date stated above, at 6.26 a m.

The CAUSE OF DEATH* was as follows:

Bronchitis & Broncho-Pneumonia

(duration) yrs. mos 23 ds.

CONTRIBUTORY (Secondary) Grad. Mitral Stenosis Heart (duration) ..... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 5314 Hamlin Av

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis Ausculation

(Signed) Ed Smith M. D.

(Address) 1600 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stone Chapel

DATE OF BURIAL Dec 4 1922

20 UNDERTAKER Wm Cook

ADDRESS 501 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Treated at Garnet Dispen.
from Nov. 6 to 13th for
Cold + Bronchio-pneumonia
Primary

BULL

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69649

D69649

CERTIFICATE OF DEATH.

REGISTERED NO. 46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 N. Broadway ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucie A. Bull

(a) RESIDENCE. NO. 917 N. Broadway ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Edward

6 DATE OF BIRTH (month, day, and year) June 25, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Thacker

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Lucie Dunne

13 BIRTHPLACE OF MOTRER (city or town) (State or country) England

14 Informant Mrs. Carey
(Address) 1623 N. Broadway

15 Filed DEC 1 - 1922 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1922

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1922, to Nov. 29, 1922, that I last saw her alive on Nov. 29, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri,

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination Johns Hopkins Hospital

(Signed) Caleb R Bliss, M. D.

, 19 (Address) 100 S. Potterson Parkway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Dec 2, 1922

20 UNDERTAKER Wm Cook

ADDRESS 502 E. Fayette Ave

A.B.—WRITE PLAINLY, with pen and ink. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69650

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69650

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Provident Hosp St. Joseph's Hospital

City of BALTIMORE: (No. St. Joseph's Hospital St., 10 Ward)

Registered No. C 188-003

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm G. Purce

(Residence in Baltimore: No. 918 Harford ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Nov 23 1908 (Month) (Day) (Year)

7-AGE. 14 yrs. mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER, George J. Purce

11-BIRTHPLACE OF FATHER, (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER, Sadie Brown

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George J. Purce

(Address) 916 Harford ave

15- Robert E. Garrison, 192 Registrar.

Burial Permit 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull - Crushed left groin left ankle & right thigh. Burns by Acid - Knock of Hydrochloric Acid

(Duration) Days yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. D. H. Toth M. D. (Coroner.)

12-1 1922 (Address) 105 E. Monument

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dennis Bros DATE OF BURIAL, Dec 4 1922

20-UNDERTAKER, C. H. Enkle ADDRESS 924 E Eager St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

(Hayer)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69651

CERTIFICATE OF DEATH.

90 ~ D69651

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2224 Washington Ro ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph a Hayer

(Residence in Baltimore: No. 2224 Washington Road St.; 75 yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Widower

6-DATE OF BIRTH, 7 (Month) 6 (Day), 1847 (Year)

7-AGE, 75 yrs. 4 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Amos Hayer

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Sallie M Hill

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie Woody

(Address) 2225 Washington Road

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11 (Month) 28 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11 15 1922, to 11 28 1922, that I saw h[illegible] alive on 11 28 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

arteria Sclerosis +
Volvular Heart disease

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) disease of old age

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos B Steele M. D.

11-30, 1922 (Address) Hyattstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL.
London Park Cem	Dec 2, 1922
20-UNDERTAKER	ADDRESS
W J Tuckner Cem	Frederick

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D69652

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 1 D69652

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 Sexton St. ST., 25 WARD)

2-FULL NAME Jacob G. Adams

(a) RESIDENCE NO. 1132 Sexton St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Adams

6 DATE OF BIRTH (month, day, and year) Oct. 31" 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	49	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country?) Baltimore, Md.

PARENTS

10 NAME OF FATHER John R. Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary E. Jeffried

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant James T. Adams

(Address) 1205 Annapolis Ave.

15 Filed DEC 1 1922, 19 ... Robert F. Duffield, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1" 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1922, to Nov 29, 1922,

that I last saw h[illegible] alive on 11-29, 1922,

and that death occurred, on the date stated above, at 2.10 P m.

The CAUSE OF DEATH* was as follows:

acute Tuberculosis

Sinai Hospital - operated on for Strangulated Hernia. Come Home with TB. Nov 17-22

(duration) ... yrs. ... mos ... da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis?

(Signed) Thos B Hall M. D.

12/1 19 22 (Address) Washington & Hammonds Ferry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL Dec 4" 1922

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bolton St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69653

CERTIFICATE OF DEATH.

31

D69653

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 52 St. Taylor Ave. (St.) (Ward) 27

2-FULL NAME Margaret Catherine Umback

(a) RESIDENCE NO. 52 St. Taylor Ave. ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married.

5a If married, widowed, or divorced
~~HUSBAND~~ (or) WIFE of Henry Umback.

6 DATE OF BIRTH (month, day, and year) Nov. 19, 1877

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
45	—	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS
10 NAME OF FATHER Henry Wiechert
11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)
12 MAIDEN NAME OF MOTHER Gertrude Hahn
13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Mrs. Geo. Wiechert.
(Address) Parkville Md.

15 Filed ....., 19.....
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1922

17
I HEREBY CERTIFY, That I attended deceased from March, 1922. to Nov. 28, 1922.
that I last saw h.r. alive on Nov. 28, 1922.
and that death occurred, on the date stated above, at 8. P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A. M. Bacon, M. D.
, 19 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Irish Roman Cemetery
DATE OF BURIAL 12/3/22

20 UNDERTAKER Geo. J. Ruth
ADDRESS 4735 Harford Ave

FC 1 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D69654

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69654

CERTIFICATE OF DEATH.

129

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2410 E. Madison ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cesidio DePetree

(Residence in Baltimore: No. 2410 E. Madison st St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) marr.

6-DATE OF BIRTH, Nov 17th (Month) (Day), 1869 (Year)

7-AGE, 53 yrs. — mos. 13 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Joseph de Petris

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Caterina DeCinco

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura DePetree

(Address) 2410 E. Madison St.

15-

Robert P. Harrison,

....., 191.....

Registrar.

Burial Permit Clerk.

12-1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 30th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1922, to Nov 29th, 1922, that I saw him alive on Nov 20th, 1922, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Cron. nephritis

..... (Duration) 2 yrs. 7 mos. ..... ds.

(Signed) Chas. J. Testa M. D.

....., 191... (Address) 210 E. 25th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Dec 4, 1922

20-UNDERTAKER Chas. Evans & Son ADDRESS 1101 W. Mt Royal Ave

1-3. Entry must be made in each of these blanks. 2. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69655

CERTIFICATE OF DEATH.

164

D69655

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 35 E. Heath ST. 23 (WARD)

2-FULL NAME Catherine Hickey

(a) RESIDENCE. NO. 35 E Heath ST., 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Hickey

6 DATE OF BIRTH (month, day, and year) May 31/1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bay to Md.

PARENTS

10 NAME OF FATHER John Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md Balto

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles Hickey

(Address) 35 E Read St.

15 Filed Dec 2-1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1922, to Nov 30, 1922, that I last saw h alive on Nov 29, 1922, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Infirmities of old age

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Retention

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Campbell M. D.

Nov, 19 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cemetery Lawn

DATE OF BURIAL 12/4 19

20 UNDERTAKER J. J. Fahey & Son

ADDRESS 1356 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

EC 2-1922

D69656 HEALTH DEPARTMENT—CITY OF BALTIMORE D69656

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1600 Division St. St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Hawkins

(Residence in Baltimore: No. 1600 Division St. (or 90135 W. 132nd St. N.Y. city) St.; yrs. mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: November (Month) (Day) 1888 (Year)

7-AGE: 34 yrs. mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: maid
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): N. Carolina

PARENTS:

10-NAME OF FATHER: James Hawkins

11-BIRTHPLACE OF FATHER, (State or Country): N.C.

12-MAIDEN NAME OF MOTHER: Ida Baskerville

13-BIRTHPLACE OF MOTHER, (State or Country): N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Hensley

(Address) 57 S.W. Biddle St.

15- Filed 1922 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November (Month) 30 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

1922 (Address) 2711 Eutaw Pl.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New York City DATE OF BURIAL: Dec 2nd 1922

20-UNDERTAKER: Samuel Hensley ADDRESS: 57 S. Biddle St

C 2

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69657

CERTIFICATE OF DEATH. 118-002

D69657

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4100 Maine Avenue ST., 15 WARD)

2-FULL NAME Mary Elizabeth Hartman

(a) RESIDENCE NO. 4100 Maine Avenue ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry C. Hartman

6 DATE OF BIRTH (month, day, and year) Mar. 24, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Vaughan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliza Stapleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Florence McDivit

(Address) 4100 Maine Avenue

15 Filed ....., 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

2-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29. 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26., 1922, to Nov. 29., 1922, that I last saw h alive on " 28., 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Strangulation from obstruction in intestines caused by growth in abdominal cavity (duration) yrs. 2 mos 3 ds.

CONTRIBUTORY (Secondary) Fibroid tumors in abdomen (duration) 13 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George A. Hartman, M. D.

, 19 (Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	12/1 19 22
20 UNDERTAKER	ADDRESS
Henry W. Meare & Son	805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS: Study this CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69658

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69658

REGISTERED NO. 190

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1814 Whitmore Ave. (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Hakesley

(a) RESIDENCE. No. 2603 W. North Ave. St.. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: late John Hakesley

6 DATE OF BIRTH (month, day, and year): 10. 9. 62!

7 AGE: Years 60 | Months 1 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Luke Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Mrs. Emily Clemmens 1814 Whitmore Ave.

15 Filed: Robert P. Harrison, Registrar

Burial Permit Clerk.

C 2 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11. 30. 1922

17 I HEREBY CERTIFY, That I attended deceased from October 1922 to November 30 1922

that I last saw her alive on November 29 1922

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Bronic Valvular Heart disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Attendance 2 months.

Senere Coma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What ~~was~~ confirmed diagnosis? Clinical

19 (Signed) Holcolt A. McCoy M. D.

11, 1922 (Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Dec 2 1922

20 UNDERTAKER: Harry H. Weitzel — ADDRESS: 1538 Lombard

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69659

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69659

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 Calhoun ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Harry Thomas

(a) RESIDENCE NO. 1629 Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	married

5a If married, widowed or divorced HUSBAND of (or) ~~WIFE of~~ Olivia Thomas

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor School 110 040

(b) General nature of industry, business, or establishment in which employed (or employer) fireman (Catonsville Day)

(c) Name of employer Balto. City

9 BIRTHPLACE (city or town) Balto. City

(State or country)

PARENTS

10 NAME OF FATHER William D. Thomas

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Taylor

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Olivia Thomas

(Address) 1629 Calhoun St.

15 DEC 2 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/29/1922

17 I HEREBY CERTIFY, That I attended deceased from 11/27/, 1922, to 11/29/, 1922

that I last saw him alive on 11/29/, 1922

and that death occurred, on the date stated above, at 12:25 p.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H. H. Jackson M. D.

(Address) 1767 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Lem DATE OF BURIAL DEC 2 1922

20 UNDERTAKER Samuel Hawley ADDRESS 578 N Fiddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 2—1922

D69660

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69660

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

City of BALTIMORE: (No. 901 S. Sharp St. St., 23 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine White.(C)

(Residence in Baltimore: No. 901 S. Sharp St. St.; yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female.	Colored	Single.

6-DATE OF BIRTH. November 30th. 1919. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
3 yrs. 0 mos. 0 ds.	hrs. or mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Eugenia Sessions.C

13-BIRTHPLACE OF MOTHER, (State or Country). Richmond, Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah White.(C)guardian.

(Address) 901 S. Sharp St.

15- Dec 2 1922 Robert F. [illegible] 192.

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 30th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Einhorn M. D. (Coroner.)

Dec. 1st 192 2. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodbrook	Dec 2 1922
20-UNDERTAKER.	ADDRESS
A. L. Blevens & Co	108 main

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Statitstics

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69661

CERTIFICATE OF DEATH.

90

D69661

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 18 WARD)

2-FULL NAME Emma Jenkins

(a) RESIDENCE NO. 825 Rayborg St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
45	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co., Maryland

PARENTS

10 NAME OF FATHER Frank Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susanna Exan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records. (Address)

15 Robert P. Garrison, Registrar

Burial Permit Clerk.

DEC 2 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1922

17

I HEREBY CERTIFY, That I attended deceased from November 24 1922, to November 30 1922.

that I last saw her alive on November 29, 1922.

and that death occurred, on the date stated above, at 8:10 A.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Aut

(Signed) Clyde McNeil, M. D.

12/1/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Dec 4 1922

20 UNDERTAKER J. L. Brownson

ADDRESS Belmont Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SH... and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69662

D69662

CERTIFICATE OF DEATH

11-002

1-PLACE OF DEATH Johns Hopkins Hospital
JOHNS HOPKINS HOSPITAL. ST., 26 WARD)
CITY OF BALTIMORE: (NO.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearlina Foster

(a) RESIDENCE NO. 1308. First. St Canton ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? ? 1916

7 AGE	Years	Months	Days	1(LESS than 1 day, ... hrs. or ..... min.
	6	1	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George Foster
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md
12 MAIDEN NAME OF MOTHER: Lena Foster
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 DEC 2 1922 19 Robert F. Hartnett Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18 , 1922 , to Nov 29 , 1922 ,
that I last saw h[illegible] alive on Nov. 29 , 1922 ,
and that death occurred, on the date stated above, at 10.30 P.m.

The CAUSE OF DEATH* was as follows:

Lymphocenzal Meningitis.

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore
Did an operation precede death? no Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Horton Casparis M. D.
, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: Dec. 3 1922
20 UNDERTAKER: H. Sander Sons ADDRESS: [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

15 1464 2 32 dau

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69663

D69663

CERTIFICATE OF DEATH.

10

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 15 WARD)

2-FULL NAME Clarence Mason

(a) RESIDENCE NO. 322 Whatcoat St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rebecca Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed Nov 28 1922 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28 1922

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1922, to Nov 28, 1922, that I last saw him alive on Nov 28, 1922, and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Nasal Diphtheria

(duration) 0 yrs. 0 mos 4 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Culture & nasal discharge positive for Diphtheria

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

48 1922

Spec.—1-10-21—M&T—1500 Bks. (Mieczyslaw Serbicki)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69664 113 D69664

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 First St. 2 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mieczyslaw Serbicki

(a) RESIDENCE No. 1733 First ST., 2 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Frank Serbicki

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Wisniewska

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Poland

14 Informant Frank Serbicki
(Address) 1733 First St

15 Filed Nov. 3, 19 22 Robert P. Garrison
Registrar
Registrar Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 19 22

17 I HEREBY CERTIFY, That I attended deceased from September 14, 1922, to November 25, 1922, that I last saw him alive on November 25, 1922, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Inanition due to

(duration) yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Frank Serbicki, M. D.

11-2, 19 22 (Address) 722 S. Ann

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 12/2 1922

UNDERTAKER Wm. Jackowski

ADDRESS 1618 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Intestinal

D69665

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69665

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH Church

City of BALTIMORE: (No. 56 or McElderry & Jones St. 5 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Burke

(Residence in Baltimore: No. 56 or McElderry & Jones St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male	Black	Married

6-DATE OF BIRTH. ....., ..., 1.....
(Month) (Day) (Year)

7-AGE. 79 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Sexton
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country). Dont Know

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country). Prince George Co

12-MAIDEN NAME OF MOTHER. Hester Coats

13-BIRTHPLACE OF MOTHER, (State or Country). Calvert Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev J W Watkins

(Address) Emmanuel Ch

15-

Filed ..... 192.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 30, 192.2.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Asphyxiation

Probably Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Fallon M. D.
(Coroner.)

12-1 192.2 (Address) 506 E. Lombard

*State the **Disease Causing Death**, or, In deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Sacred Heart	Dec 2 192.2

20-UNDERTAKER.	ADDRESS
Wm. Ulrich & Sons	1737 W Baltimore

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

DEC 2 1922

Castle Church Nov 30 12 o'clock 1899 Mr. Geo Tims in his room
for dinner in full and enjoyed. Rev Watkins &
he left him at 2 am with a supper & breakfast
apparently good health & spirits.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia.*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69666 D69666

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 13 N Montgomery ST., 27 WARD)

2-FULL NAME John Pottgiesser.

(a) RESIDENCE NO. 13 N. Montgomery ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Pottgiesser

6 DATE OF BIRTH (month, day, and year) June 20 1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68.	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cooper.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Katherine Pottgiesser
(Address) 13 N Montgomery

15 Filed ....., 19 ..... Registrar

Burial Permit Clerk.

2-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 29, 1922, to Dec 1, 1922,

that I last saw him alive on Nov 30, 1922,

and that death occurred, on the date stated above, at 4 55 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos 33 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. — ds

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Usual

(Signed) H. E. Smith, M. D.

, 19 (Address) 107 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	12-4 1922
20 UNDERTAKER	ADDRESS
Ed B. Hart	115 E. West St.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69667 HEALTH DEPARTMENT—CITY OF BALTIMORE D69667

CERTIFICATE OF DEATH. 6 129 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 105 N. Chester St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Berg

(Residence in Baltimore: No. 152 N. Stone St.; yrs., 40 mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Dec (Month) 17 (Day) 1884 (Year)

7-AGE. 74 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Metzger

(Address) 152 N. Stone St

15-

Filed ..... 192.. Robert F. Harrison, Registrar.

1922 Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 29 (Month) (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia Contributory Senility

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Walter M. D.
(Coroner)

12-1 192.2 (Address) 508 E. Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Balto Cem DATE OF BURIAL. 12/2 192.2

20-UNDERTAKER, Philip Henry Ollem ADDRESS 2016

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69668

CERTIFICATE OF DEATH

33

D69668

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 Mc Elderry ST., 5 WARD)

2-FULL NAME Mamie Hardisty

(a) RESIDENCE NO. 1425 Mc Elderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 38 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Hardisty

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General (070)

(b) General nature of industry, business, or establishment in which employed (or employer): domestic

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Dennis Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Margaret Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore md

14 Informant (Address): Jennie Adams 1425 Mc Elderry St

15 Filed ..., 19... Registrar

DEC 2-1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1922. to Dec. 1, 1922.

that I last saw her alive on Dec. 1, 1922.

and that death occurred, on the date stated above, at 5:45 a. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Chronic interstitial Catarrh

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson M. D.

(Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel

DATE OF BURIAL: Dec 4 1922

20 UNDERTAKER: John W Henderson

ADDRESS 1902 E Monument

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69669 D69669

43

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1741 Orleans ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Horace Henson

(Residence in Baltimore: No. 1741 Orleans St.: 45 yrs., mos. ds.)

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Color'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Mard

6-DATE OF BIRTH, ..., 1 ..... (Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Coal Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 045

9-BIRTHPLACE, (State or Country), a, a, Co

PARENTS.

10-NAME OF FATHER, James Henson

11-BIRTHPLACE OF FATHER (State or Country), a a Co

12-MAIDEN NAME OF MOTHER Martha Jackson

13-BIRTHPLACE OF MOTHER (State or Country), a, a, Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Henson

(Address) 1741 Orleans St

15-

Filed ..... 19..

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 29, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 9 1922, to Nov. 29, 1922, that I saw him alive on Nov 29 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Tongue

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robt. J. Green M. D.

Dec 1, 1922 (Address) 120 Aisquith St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mayfield Md DATE OF BURIAL, Dec 3, 1922

20-UNDERTAKER John W Henderson & Monument ADDRESS 1502

Spec. 6-9-19 H. P. Co. 1000 Bks.

D69670 HEALTH DEPARTMENT—CITY OF BALTIMORE D69670

CERTIFICATE OF DEATH. 113

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3412 Edmondson ave. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Jacqulin Margaret Brust

(a) RESIDENCE. No. 3412 Edmondson ST. Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Fred. Brust

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Julia Margaret Sweeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frederick Brust

(Address) 3412 Edmondson ave

DEC 2 - 1922

Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1- 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 28- , 1922, to dec 1st. , 1922, that I last saw her alive on Dec 1st. , 1922, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Marasmus, Bronchitis.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? home,

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical observation

(Signed) Victor Ribordo, M. D.

(Address) 220 Equitable Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 2, 1922
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro-Enteritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D.69671 HEALTH DEPARTMENT—CITY OF BALTIMORE D.69671

CERTIFICATE OF DEATH. 90

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers of America Hospital WARD) 11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Virginia Bennerer

(a) RESIDENCE. NO. 951 Madison ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas F Bennerer

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: 76 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Nicholas Dashiell.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Dorf Russ.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Chas F. Bennerer.

(Address) 732 Eagle St

15 Filed ..... 19 .....

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1922, to Dec 1, 1922; that I last saw her alive on Dec 1, 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Stethoscope

(Signed) Albert F. Covey, M. D.

19 (Address) Vol of America Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. DATE OF BURIAL: Dec 4 1922

20 UNDERTAKER: Wm Took ADDRESS: 520 E North

N. B.—WRITE PLAINLY with ink. All information should be stated EXACTLY. PHYSICIANS should give information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 2-1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69672

CERTIFICATE OF DEATH.

74-001 D69672

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Edmondson ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Kane

(a) RESIDENCE. NO. 1816 Edmondson ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Kane

6 DATE OF BIRTH (month, day, and year): March 8-1844

7 AGE: Years 78 Months 8 Days 21 If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: United Railways

(b) General nature of industry, business, or establishment in which employed (or employer): Employee

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: [redacted] Wm.

11 BIRTHPLACE OF FATHER (city or town) (State or country): [redacted] Ireland

12 MAIDEN NAME OF MOTHER: [redacted] Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [redacted] Ireland

14 Informant: J. M. Reilly

(Address): Druid Hill Cem Balto

15 Filed ..., 19... Registrar

DEC 2-1922

2438 Eutaw Place Dr Mayer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/1, 192...

17 I HEREBY CERTIFY, That I attended deceased from March, 1921, to November 29, 192..., that I last saw h... alive on November 29, 192..., and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) 10 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? —

(Signed) Emmett F. Mayer, M. D.

12/1, 192... (Address) 2438 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: Dec 4 192...

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Wath

mation should be carefully supplied. AGE should be stated EXACTLY. Fractions should not be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69673

CERTIFICATE OF DEATH.

101-001

D69673

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 W Balto ST.: 18 WARD)

2-FULL NAME Charles A. H. Mueller

(a) RESIDENCE. NO. 910 W Balto ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Mueller

6 DATE OF BIRTH (month, day, and year) June 24-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas. A. H. Mueller

(Address) 910 W Balto St

DEC 2 1922 , 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1922, to Nov 29, 1922, that I last saw h[e] alive on Nov 29, 1922, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia — — — 6 ds.
(duration) yrs. mos.

CONTRIBUTORY (Secondary) Exhaustion — — — 3 ds.
(duration) yrs. mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw [illegible] M. D.

12/2/1922 (Address) 51 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 2 19

20 UNDERTAKER Harry H. Witzke ADDRESS 5316 Lombard

017

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69674

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69674

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Sydenham Hospital 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Sterling La Mons

(Residence in Baltimore: No. 1530 Carroll St.; yrs. 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.): Single

6-DATE OF BIRTH: Sept. 4, 1921 (Month) (Day) (Year)

7-AGE: 1 yrs. 4 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country): Fargo. North Dacko

PARENTS.

10-NAME OF FATHER: Austin Lamont

11-BIRTHPLACE OF FATHER, (State or Country): Tennessee

12-MAIDEN NAME OF MOTHER: Mary Ellen McCoy

13-BIRTHPLACE OF MOTHER, (State or Country): Denver Colorado

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Austin Lamont

(Address) 1530 Carroll St.

15- Robert P. Harrison,

Filed DEC 2 1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec 1 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident Burns.

Toxemia—

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (Intercurrent) yrs. mos. ds.

(Signed) R. E. Lodia M. D.
Coroner.

Dec 1 1922 (Address) 1436 Bolton

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Denver Colo. DATE OF BURIAL: Dec 2 1922

20-UNDERTAKER: George J. Ruth ADDRESS: 1735 Hanford Ave

N. B.—Every item of information should be carefully supplied. Be sure and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

own death — Scarlet Fever, developed after taken to Hosp.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

D69675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69675

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4101 Gunther ave. (ST.) Gardenville (WARD)

2-FULL NAME Gottlieb Ackerman

(a) RESIDENCE NO. 4101 Gunther ave. ST., Gardenville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Ackerman

6 DATE OF BIRTH (month, day, and year) May 16th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Iris Elizabeth Ackerman

(Address) Reisterstown Md.

15 Robert P. Patterson, Burial Permit Clerk. Registrar

DEC 2 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Nov 28, 1922, that I last saw h— alive on Nov 25, 1922, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema and myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Claus Schmick, M. D.

11/29, 1922 (Address) 4702 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jerusalem Cemetery — DATE OF BURIAL Dec 3 1922

20 UNDERTAKER Fred'k Lassahn & Sons — ADDRESS Fullerton

B. WRITE plainly. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69676

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69676

REGISTERED NO. 31

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

CITY OF BALTIMORE: (No. Ft. McHenry, Balto., Md. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME HARE, Leo Edward

(a) RESIDENCE No. 313 W. 30th St., Baltimore, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Widowed, or ~~Divorced~~. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): -- Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown "

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown "

14 Informant: Hospital Records

(Address) Fort McHenry, Balto., Md.

15 DEC 2 1922 Robert P. Harrison, Registrar

Burial Permit Blank.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 1 1922.

17 I HEREBY CERTIFY, That I attended deceased from November 23 .1922. to December 1 .1922.

that I last saw him alive on December 1 .1922.

and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic, Far Advanced and Active.

(duration) Not known yrs. mos ds.

CONTRIBUTORY (Secondary) --

(duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory

(Signed) F. D. Lusk Surgeon (R) M. D.

Dec. 1, 1922 (Address) Ft. McHenry, Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 12/4 1922

20 UNDERTAKER: Henry W. Keare & Son

ADDRESS: [illegible] St.

N.B.—WRITE PLAINLY. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69677

D69677

CERTIFICATE OF DEATH.

160

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hosp.

CITY OF BALTIMORE: (No. 25 ST., WARD)

2-FULL NAME Glennys Douglas Tait Elliott City Md.

(a) RESIDENCE NO. Rockwell Ave (near Ellicott City) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Wh-	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 24- 22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
8 days-				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Agnes Hosp.

PARENTS

10 NAME OF FATHER James Tait

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER ~~Kath Tait~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant James Tait (Address) Ellicott City

15 Dec 2 1922 Robert E. Griffith Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 24- 1922, to Dec-2- 1922,

that I last saw her alive on 12-2-22, 19....,

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Inanition - Starvation

Acidosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure - Pulmonary Atelectasis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ~~Hosp~~

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) O G Caldwell M. D.

19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Agnes Cemetery DATE OF BURIAL Dec 2 1922

20 UNDERTAKER Scott M. Shipley ADDRESS Ellicott City

C. 2 - 1922

U. S.—WRITE LEGIBLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69678

D69678

CERTIFICATE OF DEATH.

74-101

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3837 Park Heights Ave ST., 45 WARD)

2-FULL NAME Henrietta T. Sachs

(a) RESIDENCE NO. 3837 Pk. Heights Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Ralph Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Theresa Feld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ralph Sachs (Address) 3837 Pk Heights Av

15 Filed Nov 1, 1922 Robert E. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1922, to death, 19....,

that I last saw her alive on Dec. 1, 1922,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ....yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertension. Chronic Nephritis

(duration) X yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urin. Blood-pressure

(Signed) Samuel Volman, M. D.

XII-1, 1922 (Address) 2464 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Dec 3 1922

20 UNDERTAKER Harry Sendheim ADDRESS 1101 Park Ave

N. B.—WRITE PLAINLY. All items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

2-1922 Burial Permit Blank

D69679

D69679

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Baton ~~St~~ 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 1014 E. Madison St

(a) RESIDENCE. NO. 1014 E. Madison ~~ST.~~ WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred one yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Col	married

5a If married, widowed, or divorced (or) WIFE of Jno. Gatch

6 DATE OF BIRTH (month, day, and year) Apr. 11. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Wm. Porter

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. J. Gatch
(Address) 1014 E. Madison St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) ~~Nov.~~ Dec 1 19 22

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24. 19 22. to Dec 1. 19 22.

that I last saw h~~er~~ alive on Nov. 30. 19 22.

and that death occurred, on the date stated above, at 2:12 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam.

(Signed) Paul Turnbaugh, M. D.

12/1, 19 22 (Address) 1002 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Dec. 3 1922
20 UNDERTAKER	ADDRESS
Thos J. G. Lortz Co.	1302 Hoffman

N. B.—WRITE PLAINLY, WITH LINK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

1558985
D69680

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69680

CERTIFICATE OF DEATH.

N35

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 1 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Daniel Edwards

(a) RESIDENCE No. 704 Penn. Ave S.E. St., ... WARD Wash. D. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Octavia Edwards

6 DATE OF BIRTH (month, day, and year) March 5, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Supt. Telephone Co.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0816

9 BIRTHPLACE (city or town) (State or country) D. C.

PARENTS

10 NAME OF FATHER James Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Caprisa Prospery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant (Address) JOHNS HOPKINS HOSPITAL. Records

15 DEC 2 - 1922 .19 Robert F. Leyden, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 9 .1922 to Dec 2, .1922 that I last saw him alive on Dec. 2 .1922 and that death occurred, on the date stated above, at 2.05 A m.

The CAUSE OF DEATH* was as follows:

Septicaemia (Staphylococcus albus)
Multiple abscesses

(duration) yrs. 1 mos 1 ds.

CONTRIBUTORY (Secondary) Prostatic abscess

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of { 10-9-22 / 10-20-22 / 10-30-22 / 10-31-22 / 11-25-22

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) F. P. Johnson, M.D. M. D.

12-2-, 1922 (Address) Johns Hopkins Hosp., Balt. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington DC

DATE OF BURIAL 12/4 1922

20 UNDERTAKER John Wendt

ADDRESS 508 Orleans

N.B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69681

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69681

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1210 W Pratt St St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Schultz

(Residence in Baltimore: No. 1210 W Pratt St St. 60 yrs., ...mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): widow

6-DATE OF BIRTH: November 20th, 1862 (Month) (Day) (Year)

7-AGE: 60 yrs. ....mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: home work.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Geo Mohr

11-BIRTHPLACE OF FATHER, (State or Country): Balto Md.

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lulu Miller

(Address) 1210 W Pratt St

15- Robert F. Harrison,

Dec 2 1922 1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 30th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to ten death on the day stated above.

The CAUSE OF DEATH* was as follows:

Second attack of apoplexy

(Duration) ....yrs. ....mos. ....ds. sudden

CONTRIBUTORY (Secondary) arterio sclerosis

(Duration) 1 yr. ....mos. ....ds.

(Signed) James M Hanlon M.D. (Coroner.)

Dec 1 1922 (Address) 700 E Lanvale

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, Dec. 4th 1922

20-UNDERTAKER, John F. Cowan & Son ADDRESS 901 Hollins St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

69682

HEALTH DEPARTMENT—CITY OF BALTIMORE

69682 D69682

CERTIFICATE OF DEATH.

161-001 D69682

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 915 N. Rose ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Sala

(a) RESIDENCE. NO. 915 N Rose ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Montalbano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Gaetana Sala

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Thomas Sala
(Address) 915 N Rose

15 Filed DEC 3 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 2, 1922, to Dec 2, 1922,

that I last saw him alive on Dec 2, 1922,

and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Premature birth
7½ - 8 months

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis A M Krauss, M. D

. 19 (Address) 3300 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec 4 1922

20 UNDERTAKER — ADDRESS 1006 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

69683

HEALTH DEPARTMENT—CITY OF BALTIMORE

69683
D69683

CERTIFICATE OF DEATH.

129 D69683

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2338 Barclay ST., 17 WARD)

2-FULL NAME Sarah C. Ghrist

(a) RESIDENCE NO. 2338 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Ghrist.

6 DATE OF BIRTH (month, day, and year) Unk 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Baltzer Kramer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Martha Getz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant James J. Edie

(Address) 2338 Barclay

15 Filed DEC 3 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 28th/22

17 I HEREBY CERTIFY, That I attended deceased from Nov 20th, 1922, to Dec 1st, 1922, that I last saw h[illegible] alive on Dec 1st, 1922, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Degeneration

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Abrahams M.D. M. D.

12/2/1922 (Address) 401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. Dec 4 1922

DATE OF BURIAL

20 UNDERTAKER Wm Cook

ADDRESS 502 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

69684 D69684

HEALTH DEPARTMENT—CITY OF BALTIMORE

69684

CERTIFICATE OF DEATH.

74-001 D69684

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 N. Arlington Ave. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Schultz.

(a) RESIDENCE NO. 920 N. Arlington Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine M.

6 DATE OF BIRTH (month, day, and year) Feb. 10 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Artist

(b) General nature of industry, business, or establishment in which employed (or employer) 001

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) " "
(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Howard L. Schultz
(Address) Fayette & East

15 Filed DEC 3-1922 ROBERT N. CARTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1922, to Dec 1, 1922, that I last saw h alive on Dec 2, 1922, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Second,

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) 2 years mos. ago ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? No Date of No.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A Crain, M. D.

, 19 (Address) 1016 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Dec 4 1922
20 UNDERTAKER Wm Cook	ADDRESS 632 E. N. Ave

Spec.—8-24-14—M. & T.—2000 Bks. Letter attached

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69685

CERTIFICATE OF DEATH.

101-001 D69685

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 W. Baltimore St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Fox

(Residence in Baltimore: No. 611 W. Baltimore St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Single

6-DATE OF BIRTH Unknown (Month) (Day), 1876 (Year)

7-AGE, ~~44~~ 46 yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William Fox

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Sarah —

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Baltimore St

15- DEC 3 - 1922

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 1 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30 1922, to Dec 1 1922, that I saw him alive on Dec 1 1922, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edwin R. Ballard M. D.

Dec 1, 1922 (Address) 1622 Mt Royal Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship Cem. DATE OF BURIAL, Dec 3, 1922

20-UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Dr C. Hampson Jones;
Commissioner of Health.

Dear Sir: Through error of information, the age of Joseph Fox - 611 W. Baltimore St - was given on his death certificate as 42 yrs. His correct age, as since given by an aut of town relative, was 46 yrs. 1 mo. & 7 days. By kindly having the correction made on the death certificate, You will oblige

Yours respectfully,
E. K. Ballard M.D.

DEC 5 - 1922

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STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

Abortion,	*Cellulitis,*	*Cinnabarin,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Bks.

69686 D69686

HEALTH DEPARTMENT—CITY OF BALTIMORE

69686 90 D69686

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2433 E. Chase ST., 8 WARD)

2-FULL NAME Jeremiah J. O'Donohue

(a) RESIDENCE No. 2433 E. Chase ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida McDonohue

6 DATE OF BIRTH (month, day, and year): May 1st

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	7.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Lumdell

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Daniel O'Donohue

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Im Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): / /

14 Informant: Ida McDonohue
(Address): 2433 E Chase St

15 Filed DEC 3 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 15th, 1922, to Dec 1, 1922, that I last saw h— alive on Nov 30, 1922, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis. Contributory

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Nephritis

(duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) Alan F3 Lumsden, M. D.

12/1/22 (Address) 748 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec 4 1922

20 UNDERTAKER: Jos. H. Finck & Son — ADDRESS: 811 N Wolfe

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—6-9-19—H. P. Co.— 1000 Bks.

69687 D69687

HEALTH DEPARTMENT—CITY OF BALTIMORE

69687

CERTIFICATE OF DEATH. X 112

D69687

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara A. McCloskey

(a) RESIDENCE. No. Mt Hope Retreat ST. 28th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

mation should be carefully supplied. Age should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 6-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER John McCloskey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Co Derry Ireland

12 MAIDEN NAME OF MOTHER L. McElwee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Pa

14 Informant Records of Mt Hope Retreat

(Address) Baltimore Md

15 Filed DEC 3-1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1922, to Dec 2, 1922,

that I last saw h[illegible] alive on Dec 2, 1922,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis —

(duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Mania — Elevated Temp

(duration) 0 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? Phila Pa

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa

DATE OF BURIAL 12-2 1922

20 UNDERTAKER Henry Justice & Sons Co

ADDRESS Hillsdale Orchard

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69688 D69688

CERTIFICATE OF DEATH. 135

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 13 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Schneier Michelson

(a) RESIDENCE. No 2230 Eutaw Pl. WARD.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Esther Michelson

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8 y	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hebrew Writer and Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Wolf Michelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dunkan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hosp Records
(Address)

15 Filed DEC 3 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/1 1922

17 I HEREBY CERTIFY, That I attended deceased from 11/20, 1922 to 12/1, 1922 that I last saw h~~im~~ alive on 12/1, 1922 and that death occurred, on the date stated above, at 5 50 P m.

The CAUSE OF DEATH* was as follows:

Uremia following Pyelonephritis (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Benign Hypertrophy Prostate (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/28/22

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. H. Cubens, M. D.

12/3, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Hebrew Cemetery	12/3 1922
20 UNDERTAKER Jack Lewis	ADDRESS 1429 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D69689

D69689

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 19 WARD)

2-FULL NAME Louis ~~Bank~~ Bank

(a) RESIDENCE. NO. 527 N. Gilmor ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

N. B.—Many physicians have neglected to have their certificates properly filled out. Please read carefully. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	~~Single~~ Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Bank

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E. Balto St

15 Filed DEC 3 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/2 19 22

17 I HEREBY CERTIFY, That I attended deceased from November 30, 19 22, to December 2, 19 22, that I last saw him alive on December 2, 19 22, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Carcinoma.

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Moses Gelman, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Cemetery	12-3 19 22
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E. Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69690

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 159-003 D69690

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 S. Bond ST.: 3 WARD)

2-FULL NAME Baby Pressman

(a) RESIDENCE. NO. 204 S. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wh	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 12-2-22

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED ✓

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Samuel Pressman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Yoba Dowbel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Yoba Pressman (Address) 204 S Bond st

15 Filed DEC 3 - 1922, 19 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 2nd, 1922, to Dec 2nd, 1922, that I last saw her alive on , 19 , and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Deformed Monster (Hemicephalus)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) ✓ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Winner, M. D.

12-2, 1922 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 12/3 1922

20 UNDERTAKER Hoch Louis ADDRESS 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69691 46 D69691

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Howard A. Kelly Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Wigmstein

(a) RESIDENCE. NO. Johnny Cake Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Wigmstein

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1439 E. Balto. St.

15 Filed DEC 3 1922 ROBERT N. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to Dec. 2, 1922; that I last saw h[illegible] alive on Dec. 3, 1922, and that death occurred, on the date stated above, at 6.15 a.m.

The CAUSE OF DEATH* was as follows:

Papillary carcinoma ovary with peritoneal implantations & metastasis to liver.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of May 23, 1922

Was there an autopsy? No.

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) Arthur C. Primrose, M. D.

12/3, 1922 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington Mt. Carmel	12-3-1922
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E. Balto. St.

mation should be carefully supplied. Age should be stated in years. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16960 8
D69692

CERTIFICATE OF DEATH.

D69692

REGISTERED NO. 112

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stewart Thompson.

(a) RESIDENCE No. 1546 N. Carey St. City ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Lewis & Violet Thompson Parents

6 DATE OF BIRTH (month, day, and year) May 14 1922.

7 AGE — Years — Months 6 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

PARENTS

10 NAME OF FATHER: Lewis Briscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Violet Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Riverdale

15 Filed DEC 3-1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9 , 1922, to Dec 2 , 1922, that I last saw him alive on Dec 2 , 1922, and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Diarrhea (not dysentery)

(duration) 0 yrs. 3½ mos. ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) 0 yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of Dec.

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Dec 5 1922

20 UNDERTAKER: Davis Euster

ADDRESS: 916 Penna Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should read CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69693

D69693

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 318 Myrtle Ave ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mammie Emma Robinson

(a) RESIDENCE. NO. 318 Myrtle Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of James Robinson

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
41	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer Mrs Beaver

9 BIRTHPLACE (city or town) (State or country) Ft. C.

PARENTS

10 NAME OF FATHER Alexander Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rebecca Morbus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Daniel Easton (Address) 916 Pa ave

15 Filed DEC 3 - 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-2-22 19

17 I HEREBY CERTIFY, That I attended deceased from Nov 25 —, 1922, to Dec 1st, 1922

that I last saw her alive on Dec 1st, 1922,

and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jas C Cuppa, M. D.

19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 4 1922
20 UNDERTAKER Daniel Easton	ADDRESS 916 Penna Ave

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69694

D69694

CERTIFICATE OF DEATH.

46

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 Oxford ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Tilghman

(a) RESIDENCE. NO. 507 Oxford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Edward Tilghman

6 DATE OF BIRTH (month, day, and year) July 15, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Fannie Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Daniel Easton

(Address) 916 Fa Ave

15 Filed DEC 3 - 1922 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1922, to Nov. 30, 1922, that I last saw h[illegible] alive on Nov. 26, 1922, and that death occurred, on the date stated above, at 3.20 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute articular Rheumatism (duration) — yrs. 1 mos. 25 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. S. Pelletreau, M. D.

, 19 (Address) 817 Hamilton Terr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 3 1922

20 UNDERTAKER Daniel Easton ADDRESS 916 Fa Ave

NO. 15. WHITE PAPER, WITH CARBON FOR THIS BLANK IS APPROPRIATELY RECOMMENDED. Item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D69695

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D69695

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 Brice St ST. 20 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis A. Streb

(Residence in Baltimore: No. 522 Brice St St.: 25 yrs.,.....mos.....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH. May 7th, 1822 (Month) (Day) (Year)

7-AGE. 50 yrs. 6 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). City Fire Dept

9-BIRTHPLACE, (State or Country). Balto Co, Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary E. Streb

(Address) 522 N. Brice St

15- DEC 3 - 1922 1922 ROBERT R. KRAUTER, Burial Permit Clerk..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 1, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5th 1922, to Dec 1st 1922, that I saw h~~im~~ alive on Dec 1st 1922, and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) C. L. Krammes M. D.

Dec 4, 1922 (Address) 1924 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Woodlawn Cemetery

DATE OF BURIAL. Dec 4, 1922

20-UNDERTAKER Jos Jourdens + Son

ADDRESS 217 S. Paca

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D69696

D69696

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 315 N. Carey ST., 18 WARD)

2-FULL NAME Jas B. Tarlton

(a) RESIDENCE NO. 315 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tarlton.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Tarleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Tarleton Morgan

(Address) 1623 N. Bentalou St

15 DEC 3-1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1. 1922 19

17 I HEREBY CERTIFY, That I attended deceased from July 1. 1922. to Dec 1 .1922.

that I last saw h alive on Dec 1 .1922.

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Heart dilatation

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Arterio - Sclerosis -

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? None Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Young, M. D.

, 1922 (Address) 1425 Eutaw Place -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Dec 4 1922

20 UNDERTAKER Geo J Smith

ADDRESS 1532 Hollins

N. B.—WRITE PLAINLY, with ink. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69697

CERTIFICATE OF DEATH.

100-001

D69697

REGISTERED NO.

1-PLACE OF DEATH Robt Garrett Hosp

CITY OF BALTIMORE: (No.) 27 N Carey ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Mc Manus

(a) RESIDENCE NO. 370 S. Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6 1922

7 AGE — Years: — Months: 6 Days: 26 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Mc Manus

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lillian Doonan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant John Mc Manus (Address) 370 S. Woodyear S.

15 DEC 3 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1922, to Dec 2, 1922, that I last saw h[illegible] alive on Dec 2, 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

6 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of Buttocks

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

12/2, 1922 (Address) 27 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Peters Cem — DATE OF BURIAL: Dec 4 1922

20 UNDERTAKER: Joseph B. Cook — ADDRESS: 1003 W. Baltimore St

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69698

D69698

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Md. General Hospital ST., 24 WARD)

2-FULL NAME Baby Monte

(a) RESIDENCE NO. 1205 Williams ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Nov. 20 - 1922

7 AGE — Years: ..... Months: ..... Days: 12 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto. Maryland.

PARENTS

10 NAME OF FATHER: Anthony Monte

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Louise Heil

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Maryland

14 Informant: Louis Monte

(Address) 1205 Williams St

15 Filed DEC 3 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day) Dec. 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1922 to Dec 2, 1922

that I last saw h alive on Dec 2, 1922

and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? None Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) George E. Shannon M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem.

DATE OF BURIAL: Dec 4 1922

20 UNDERTAKER: F. A. Trance & Son

ADDRESS: 703 Hanover St

N. B.—WRITE PLAINLY. All items must be answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69699

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D69699

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1334 Argyle Ave., 17 WARD)

2-FULL NAME John A Clarkson Jr.

(a) RESIDENCE (No. 1334 Argyle Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Rosa Clarkson

6 DATE OF BIRTH (month, day, and year) June 18-1877

7 AGE — Years: 45 — Months: 5 — Days: 12 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B. & O. Sumter S. C.

9 BIRTHPLACE (city or town) (State or country): S. C.

PARENTS

10 NAME OF FATHER: John Clarkson Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sumter S. C.

12 MAIDEN NAME OF MOTHER: Sarah Clarkson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Rosa Clarkson

(Address): 1334 N ~~Fulton Ave~~

15 FILED DEC 3-1922 ROBERT J. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar, 1922, to Nov 30, 1922,

that I last saw him alive on Nov 30, 1922,

and that death occurred, on the date stated above, at 4 40 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 1/2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. D. Woolridge, M. D.

12/3. 1922 (Address) 1037 Fayette Ave Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lakewood S. C.

DATE OF BURIAL: 12/3 1922

20 UNDERTAKER: Edward L. Hemler

ADDRESS: 578 N Bond

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69700

CERTIFICATE OF DEATH.

131

D69700

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 N. Gilford ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cristina Blanco

(a) RESIDENCE NO. 1120 N. Gilford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug - 30 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Edward F. Blanco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Inez Hanks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Edward F. Blanco

(Address) 1120 N. Gilford St.

15 Filed DEC 3 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec, 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1922, to Dec 2, 1922.

that I last saw h[illegible] alive on Dec 2, 1922.

and that death occurred, on the date stated above, at 4:20 p m.

The CAUSE OF DEATH* was as follows:

Uremia & suppression of urine

(duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary) Cold

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John H Tomkins M. D.

19 (Address) 1019 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 12/4 1922

20 UNDERTAKER Samuel Hensley

ADDRESS McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK. The information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

331 D69701

REGISTERED NO. D69701

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (NO.) 3953 Falls Road ST., 13 (WARD)

2-FULL NAME Elnora A. Johnson

(a) RESIDENCE NO. 3953 Falls Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 5 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: C. Edward Johnson

6 DATE OF BIRTH (month, day, and year): June 2-1897

7 AGE — Years: 25 — Months: 5 — Days: 27 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Henry C. Gaunt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Maryland

12 MAIDEN NAME OF MOTHER: Mary E. Woodward

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): C. Edward Johnson 3953 Falls Road

15 DEC 3-1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1922, to Nov. 29, 1922, that I last saw her alive on Nov. 29, 1922, and that death occurred, on the date stated above, at 10.10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) .. yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Tubercular Peritonitis (duration) ..yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Mackin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hampden — DATE OF BURIAL: Dec. 4 1922

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 362 Falls Road

N. B.—WHITE LEGIBLY, WITH INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D69702

D69702

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 N. Carey ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Meserroll Carlyle

(a) RESIDENCE. No. 627 N. Carey ST., WARD. 16th

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Henry Wilson Carlyle

6 DATE OF BIRTH (month, day, and year) Oct 25 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harlingen Somerset Co. N. J.

PARENTS

10 NAME OF FATHER Aaron Meserroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harlingen N. J.

12 MAIDEN NAME OF MOTHER Catherine Susan Hageman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harlingen N. J.

14 Informant George Carlyle (son)

(Address) 13 N. Gilmor St.

15 Filed DEC 3 - 1922 ROGER N. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from January 5th, 1922, to December 1st, 1922, that I last saw her alive on December 1st 1922, and that death occurred, on the date stated above, at 1.35 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia over 7

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Arterio sclerosis (duration) about yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. H. Winter Clift, M. D.

12/1, 1922 (Address) 1312 N. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL LOUDON PARK

DATE OF BURIAL 12/4 1922

20 UNDERTAKER ROBERT T. BROOKS SON

ADDRESS CALHOUN HOLLINS

N. B.—WHITE CARDS, WHITE CARDS. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.) "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

13 9777 D69703 69703 69703 90 X 2 D69703

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) ..... JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME John William Allen

(a) RESIDENCE NO. 87 Nicodemus Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Pikesville

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of ~~(or) WIFE~~ of Florence Allen

6 DATE OF BIRTH (month, day, and year) June 16, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dr. Wm. Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary J. Schweitzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 DEC 3-1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 - 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 11 - 1922, to Dec 1 - 1922, that I last saw him alive on Dec 1 - 1922, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis & Insufficiency
Auricular Fibrillation
Pulmonary Infarction

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Chas. R Bagg, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL Dec 4 1922

20 UNDERTAKER Wm Fleckner Sons — ADDRESS 7 N Pa

N. B.—WRITE PLAINLY, with indelible pencil. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69704

CERTIFICATE OF DEATH.

31

D69704

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 N. Mount ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Scribner

(Residence in Baltimore: No. 310 Mount St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month) (Day), 1883 (Year)

7-AGE, 39 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 0"10

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, David Scribner

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Alton

(Address) 310 N. Mount St

15. Filed DEC 4-1922, 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued. Clerk.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12th (Month) 1st (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9/15 1922, to 12/1 1922, that I saw her alive on 12/1 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) B. W. Kelly M. D.

12/1, 1922 (Address) 4133 Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, Dec. 4, 1922

20-UNDERTAKER John H. Toadvine

ADDRESS 142 Ostend St

N. B.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69705 CERTIFICATE OF DEATH. 90 D69705

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425-E-Biddle ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Eliza Hasson

(a) RESIDENCE NO. 1425-E-Biddle ST., 10 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? 78 yrs. 10 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Alex. Hasson

6 DATE OF BIRTH (month, day, and year) January-11-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Millar

11 BIRTHPLACE OF FATHER (city or town) Londonderry
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Anderson

13 BIRTHPLACE OF MOTHER (city or town) Belfast
(State or country) Ireland

14 Informant Miss Mary E. Hasson (daughter)
(Address) 1425-E-Biddle St.

15 DEC 4 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1922 to Dec 2, 1922

that I last saw h-e alive on Dec 2nd, 1922

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valv. Endocarditis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Gangrene of Both Legs

(duration) — yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? No Date of "

Was there an autopsy? No

What test confirmed diagnosis? "

(Signed) Jeffries Reed M.D.

Dec 3, 1922 (Address) 2844-82 Pine St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmitsburg Cemetery

DATE OF BURIAL Dec 4 1922

20 UNDERTAKER STEWART & MOWEN COMPANY
(WILLIAM F. WOODEA, Successor)

ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Tho question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. Tho contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Diabetic

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69706

CERTIFICATE OF DEATH.

88 D69706

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

2-FULL NAME Hannah M. Brown

(a) RESIDENCE. No. Mt Hope Retreat ST. 28 WARD. Germantown Pa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 66 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) About 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	66	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk -

(b) General nature of industry, business, or establishment in which employed (or employer) Clerking - 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germantown Pa

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country) " "

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) " "

14 Informant Records of Mt Hope Retreat - (Address) Mt Hope Baltimore

15 Filed DEC 4 - 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1890 m. to Dec 2nd 1922. that I last saw her alive on Dec 1st 1922. and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis -
Complicated by Gastritis

abt (duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) Terminal Dementia Post
Or Melancholia (duration) Abt 36 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Germantown Pa

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

Dec 2nd 1922 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Dec - 4 - 1922

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Semmler

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69707

57 D69707

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1106 E. Lanvale ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Semmler Sr

(a) RESIDENCE. NO. 1106 E. Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 39 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
66		9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer) 66

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Semmler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Semmler Jr

(Address) 1004 Fulton ave

15 DEC 4 - 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1922, to Dec 1, 1922, that I last saw him alive on Dec 1, 1922, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Embolic Coronary Arteries?
Chronic Interstitial Nephritis. Diabetes
& Necrosis. Meta tarsal bone of L foot

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis, Diabetes & Necrosis Meta tarsal of foot (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .

Was there an autopsy? no

What test confirmed diagnosis? Urinary Analysis

(Signed) C. B. Carman, M. D.

12 2 1922 (Address) 1701 N Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 6 1922
20 UNDERTAKER	ADDRESS
J. Schamahorn	1004 Fulton st

mation should be carefully supplied. AGE should be stated EXACTLY. FRACTIONS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D69708

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D69708

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L. Hall

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 615

9 BIRTHPLACE (city or town) (State or country): Kent Co., Maryland

PARENTS

10 NAME OF FATHER: William J. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent Co., Maryland

12 MAIDEN NAME OF MOTHER: Hannah Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co., Maryland

14 Informant (Address): Municipal Hospital Records.

15 Filed DEC 4-1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 2 1922

17

I HEREBY CERTIFY, That I attended deceased from November 27, 1922, to December 2, 1922, that I last saw him alive on December 1, 1922, and that death occurred, on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 43 yrs. mos ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) 3 yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Refused

What test confirmed diagnosis? Was. Soahs Negative

(Signed) Clyde McNeil M. D.

12/2/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Brooklyn — DATE OF BURIAL: Dec 4 1922

20 UNDERTAKER: F.A. Krause & Son — ADDRESS: 703 Hanover

N. B. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69709 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 46 D69709

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 S. Sharp ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna L. Williams

(a) RESIDENCE. NO. 521 S. Sharp ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roger F. Williams

6 DATE OF BIRTH (month, day, and year) Apr 17 - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Armiger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliz. Tanner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Lee Williams

(Address) 521 S. Sharp st

15 Filed . 19 ROBERT R. KRAUTER Registrar

DEC 4 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 1 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 15. 1921. to Nov. 30. 1922.

that I last saw h alive on Nov. 30. 1922

and that death occurred, on the date stated above, at 5.10 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus and Bladder

(duration) 1 yrs. 4 mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 15-1921

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) [illegible] M. D.

12/1 1922 (Address) 1412 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Dec 3 1922
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

N. B.—WRITE CLEARLY, with pen and ink. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69710

CERTIFICATE OF DEATH.

100-001 D69710

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1002 W Cross St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose V Brady

(Residence in Baltimore: No. 1002 W Cross St.; ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Sept 7, 1862
(Month) (Day) (Year)

7-AGE, 60 yrs. 2 mos. 26 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work HW
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Geo Clifton

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mrs Emma

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Brady

(Address) 1002 W Cross St

15-

Filed....., 191.. ROBT. P. KRAUTER, Registrar.

DEC 4 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 3, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1922, to Dec. 3 1922; that I saw h[illegible] alive on Dec 2 1922, and that death occurred, on the date stated above, at 5.35 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John G. Schwatka M. D.

Dec 3 1922 (Address) 11 N Howard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Dec 4, 1922

20-UNDERTAKER John J Fields

ADDRESS 1200 W Lombard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Spec.—1-10-21—M&T—1500 Bks.

D69711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D69711

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 10 Darlington av ST., 18 WARD)

2-FULL NAME Melvinia E. Smith

(a) RESIDENCE No 10 E Arlington av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) May 17 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Howard Smith

(Address) 10 E Arlington av

15 Filed DEC 4 1922 19 ROBERT R. KRAUTER, Burial Permit Clerk. Reviewer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/4/22 19

17 I HEREBY CERTIFY, That I attended deceased from 11/11/22, 19, to 12/4/22, 19, that I last saw her alive on 12/1/22, 19, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 dy

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Original Univ Hosp

(Signed) Bernard J. Long, M. D.

12/4, 19 22 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Dec 6 1922

20 UNDERTAKER John J. Fields — ADDRESS 1200 W Lombard st

A. B. Illegible should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69712

CERTIFICATE OF DEATH.

74-001 D69712

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 543 N. Bare. (St.) 22 (Ward)

2-FULL NAME Christina Hemstaedt

(a) RESIDENCE NO. 543 N. Bare. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. - mos. ds. How long in U. S., if of foreign birth? 40 yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adam Hemstaedt

6 DATE OF BIRTH (month, day, and year): April 19. 1861

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
61	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Heinrich von Berg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Fensel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Adam Hemstaedt (Address) 543 N. Bare St

15 Filed DEC 4 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1. 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1922, to Dec 1, 1922, that I last saw her alive on Nov 30, 1922, and that death occurred, on the date stated above, at 4:50 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 4 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mary D. Browne M. D.

Dec 1922 (Address) Rochambeau Ap'ts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cemetery — DATE OF BURIAL: Dec. 4 1922,

20 UNDERTAKER: Mr. Mrs. John H. Teufel & Son — ADDRESS: 801 N. Fayette

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69713

CERTIFICATE OF DEATH.

D69713

99-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Mt St Agnes Convent ST., 25 WARD)

2-FULL NAME Sr. M. Stanislaus Mathews,

(a) RESIDENCE NO. Mt St Agnes Convent ST., 24 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): January 9 1847

7 AGE — Years: 84 Months: 10 Days: 27 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: Sister Mercy

9 BIRTHPLACE (city or town) (State or country): Cuba

PARENTS

10 NAME OF FATHER: James Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country): no Known

12 MAIDEN NAME OF MOTHER: no Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cuba

14 Informant (Address): Sr M. Angela Mt St Agnes Convent

15 Filed DEC 4 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 1 1922

17 I HEREBY CERTIFY, That I attended deceased from 1891 to Dec 1 1922 that I last saw her alive on Nov 28 1922 and that death occurred, on the date stated above, at 1130 a m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Abt (duration) 7 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Dilated heart

Abt (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Milligan & Todd, M. D.

, 19 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt St Agnes Convent Baltimore	Dec 4 1922
20 UNDERTAKER	ADDRESS
Henry Heuisler	1006 N Eutaw

N. B.—WRITE PLAINLY, WITH CARBON PAPER. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69714 D69714

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 13 N. Schroeder St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel C. Riley

(Residence in Baltimore: No. 13 N. Schroeder St.; yrs. 52 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: January (Month) 1 (Day) 1870 (Year)

7-AGE: 52 yrs. 9 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto md

PARENTS.

10-NAME OF FATHER: Saml Riley

11-BIRTHPLACE OF FATHER, (State or Country): md

12-MAIDEN NAME OF MOTHER: Dan't Kru

13-BIRTHPLACE OF MOTHER, (State or Country): i c r

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Catherine Riley

(Address) 13 N. Schroeder

15-

Filed DEC 4 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 30 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

..... (Duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) Dropsy

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Conrad M. D. (Coroner.)

1922 (Address) 1317 Eutaw St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Dec 4 1922

20-UNDERTAKER: Mrs J. E. Evans & Sons ADDRESS 142 N. Charles St.

N. B.—Every item of information should be carefully supplied. Where unknown state so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~159969~~ ~~D69715~~

38 D69715

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Lenard.

(a) RESIDENCE No. 914 Mc Cullough St. City WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Alice Lenard (wife).

6 DATE OF BIRTH (month, day, and year) Dec. ? 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	48	11	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): (H)

(c) Name of employer: (H)

9 BIRTHPLACE (city or town) (State or country): (H) Maryland.

PARENTS

10 NAME OF FATHER: Robert Lenard.

11 BIRTHPLACE OF FATHER (city or town) (State or country): (H) Maryland

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Maryland

14 Informant: JOHNS HOPKINS HOSPITAL. (Address) Baltimore

15 DEC 4 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1922 to Nov. 29, 1922.

that I last saw him alive on Nov. 29, 1922.

and that death occurred, on the date stated above, at 10 1/2 P. m.

The CAUSE OF DEATH* was as follows:

Aneurism of aorta

Duration

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas R Bagg, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lawn Lawn — DATE OF BURIAL: Dec 4 1922

20 UNDERTAKER: Brown & Kirkland — ADDRESS 114 [illegible] Baltimore

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lactic

D69716 HEALTH DEPARTMENT—CITY OF BALTIMORE

D69716

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 12 Ward) 192

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Jackson

(Residence in Baltimore: No. 2112 E. 23rd St.; yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PROFESSIONAL TERMS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Col'd	Married

6-DATE OF BIRTH. ..... (Month) ..... (Day) ..... (Year)

7-AGE. 33 Yrs. 8 Mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country). Md.

PARENTS:

10-NAME OF FATHER. Henry Jackson

11-BIRTHPLACE OF FATHER, (State or Country). ~~Baltimo~~ Md

12-MAIDEN NAME OF MOTHER. Rebecca Brown

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Smith

(Address) Middle River

15-

Filed DEC 4 - 1922 192 ROBERT R. KRAUTER, Registrar.

Burial ... 192 ...

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov. (Month) 30 (Day) 27 (Year) 192...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Died from shot wound of chest

Said to be homicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

192... (Address) ...

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cem	Dec 5 1922

20-UNDERTAKER	ADDRESS
Brown & Sisson	1145 Lanvale St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69717

D69717

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 N. Mount ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Duvall

(Residence in Baltimore: No. 11 N. Mount St. St.; ....yrs., ...mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	

6-DATE OF BIRTH, Nov ~~Dec~~ 30, 1922
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
....yrs....mos. 2 ds.	....hrs. or....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Geo E. Duvall

11-BIRTHPLACE OF FATHER (State or Country). Ill.

12-MAIDEN NAME OF MOTHER Blanche Overcashe

13-BIRTHPLACE OF MOTHER (State or Country). Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A D Harman M D

(Address) Franklin Sq. Hosp.

15- DEC 4 1922 ROBERT A. KNAUER, 191.....
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 30 1922, to Dec 2 1922, that I saw h~~i~~e alive on Dec 1 1922, and that death occurred, on the date stated above, at 1.5 Am.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary).....

(Duration)....yrs....mos....ds.

(Signed) A D Harman M. D.

Dec 2, 1922 (Address) Franklin Sq. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	Dec 4, 1922
20-UNDERTAKER Henry Hooch & Son	ADDRESS 1301 E Eager St

N. B.—Every item of information should be carefully sought for and be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69718

CERTIFICATE OF DEATH.

129

D69718

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST.: 6 WARD)

2-FULL NAME Morris B. Schochet

(a) RESIDENCE. NO. 2126 E. Baltimore ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY. WITH LEAD PENCIL. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Shochet

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Shepsel Chaim Shochet

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachael Ephrain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1409 E Baltimore St

15 Filed DEC 4 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1922, to Dec. 3rd, 1922; that I last saw h[illegible] alive on Dec. 3rd, 1922, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - Hypertension + Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory Test

(Signed) Moses Gellman, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mech Road	12/4 1922
20 UNDERTAKER	ADDRESS
Jack Levis	1439 E Balt St

Spec.—1-10-21—M&T—1500 Blks.

D69719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3rd D69719

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 26 WARD)

2-FULL NAME Emil Lastovka

(a) RESIDENCE No. 21 Powell ave, Belair Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Lastovka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant (Address) Hospital Records M. T. H.

15 Filed DEC 4 1922, 19.... ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1922, to Dec. 2, 1922, that I last saw him alive on Dec. 2, 1922, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Frederick L. Dalaglesca M. D.

12-3 1922 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec 6 1922

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 Eager

N. B.—WHITE PAPER, must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

D69720

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69720

CERTIFICATE OF DEATH.

84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1935 W. Lombard ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Frame

(a) RESIDENCE. NO. 1935 W. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of L. S. Frame

6 DATE OF BIRTH (month, day, and year) Mar. 17, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	8	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rockbridge Co. Va.

PARENTS

10 NAME OF FATHER Whitmore.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Ernest H. Frame

(Address) 1935 W. Lombard St

15 Filed DEC 4-1922, 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/1/22 19

17 I HEREBY CERTIFY, That I attended deceased from July, 1922, to Dec 1, 1922, that I last saw her alive on Dec. 1, 1922, and that death occurred, on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor
Type undetermined

(duration) yrs. 4 mos. 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs only

(Signed) W. N. Sifford, M. D.

19 (Address) 1324 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 4 1922
20 UNDERTAKER	ADDRESS
Harry H Ketchum	1531 W Lombard St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69721 101-001 D69721

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 437 Bloom ST. 14 WARD)

2-FULL NAME John Blackston

(a) RESIDENCE NO. 437 Bloom ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) [illegible] 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer .....

9 BIRTHPLACE (city or town) Annapolis (State or country) Anne Arundel Co Md

PARENTS

10 NAME OF FATHER Isaac Blackston

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Sullivan

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Nannie Carter (Address) 437 Bloom St

15 Filed DEC 1 - 1922 19 ..... Registrar

ROBERT B. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 1, 1922, that I last saw him alive on Dec. 2, 1922, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Diphtheria Antitoxin Given

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Pneumococcus

(Signed) Simon F Keey, M. D.

12-1 1922 (Address) 3705 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenlawn Talbot Co Md — DATE OF BURIAL 12/5 1922

20 UNDERTAKER Saml P Kennedy & W Biddle — ADDRESS 578

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS BLANK MUST BE FILLED OUT EXACTLY. PHYSICIANS should state AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. CAUSE OF DEATH is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69722

CERTIFICATE OF DEATH.

90 D69722

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2326 E. Fayette ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Job Fosler

(a) RESIDENCE NO. 2326 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ late Laura V. Fosler

6 DATE OF BIRTH (month, day, and year) Apl 21-44

7 AGE — Years: 78 — Months: 9 — Days: 11 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Ship Joiner

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Job Fosler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Marie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs J. Fosler

(Address) 2326 E. Fayette

15 Filed 4-1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922 to Dec 2, 1922 that I last saw h[illegible] alive on Dec 1, 1922 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(duration) 1 yrs. [illegible] mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Levy M. D.

12/3. 1922 (Address) 413 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: 12/5 1922

20 UNDERTAKER: Philip Henrig — ADDRESS: 2016 Aliceanna

Burial Permit Clerk.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. **Examples:** *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Fatty Degeneration of Heart

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69723

CERTIFICATE OF DEATH.

49 D69723

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. Eastern Ave ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alonoza Hubbard

(a) RESIDENCE NO. 1923 Eastern Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 19 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	49	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balti. Md

PARENTS

10 NAME OF FATHER: Alonoza Hubbard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balti Md

12 MAIDEN NAME OF MOTHER: Margaret A. Hubbard Henderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balti Md

14 Informant: Municipal Hosp. Records (Address) "

15 Filed DEC 4 1922 ROBERT R. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1 1922

17 I HEREBY CERTIFY, That I attended deceased from 10-21 1922, to 12-1 1922

that I last saw him alive on 12-1 1922

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2m October

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J. Richardson Joyce M. D.

(Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem. DATE OF BURIAL: 12/4 1922

20 UNDERTAKER: Philip Hennig ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69724

HEALTH DEPARTMENT—CITY OF BALTIMORE

43 D69724

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2926 O'donnell ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos. F. Murphy

(a) RESIDENCE NO. 2926 O'donnell ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 14-52

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Candy Store

(c) Name of employer Himself

045

9 BIRTHPLACE (city or town) (State or country) Cork Ireland

PARENTS

10 NAME OF FATHER Peter Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elenora

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Evans

(Address) 2924 Odonnell St.

15 Filed DEC 4 — 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1922 to Dec - 2 1922

that I last saw him alive on Dec 2 1922

and that death occurred, on the date stated above, at 12 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Superior Maxillae

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M J McAvoy, M. D.

12/3, 1922 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL 12/5 1922

20 UNDERTAKER Philip Herwig — ADDRESS 206 Aisquith

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69725

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D69725

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1039 W Saratoga ST. 18 WARD)

2-FULL NAME Wiley Covington

(a) RESIDENCE NO. 1039 W Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 28, 1921

7 AGE Years 1 Months 3 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED Nil

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Wiley Covington

11 BIRTHPLACE OF FATHER (city or town) New Port News (State or country) Virg

12 MAIDEN NAME OF MOTHER Viola Golden

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Viola Golden

(Address) 1039 W Saratoga

15 DEC 4 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1922, to Dec 1, 1922,

that I last saw him alive on Dec 1st, 1922,

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. T. Howell M. D.

12/3/1922 (Address) 119 N Carey Med Chir

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Dec 4, 1922.

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 1114 W. Saratoga St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. mation should be properly classified. Exact statement of OCCUPA- so that it may be CAUSE OF DEATH in plain terms, See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69726

CERTIFICATE OF DEATH.

101-001 D69726

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1039 W Saratoga ST. 18 WARD)

2-FULL NAME Vincent Green

(a) RESIDENCE NO. 1039 W Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. The following items must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 17, 1918

7 AGE — Years: 4 — Months: 2 — Days: 15 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jerry Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Viola Golden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Viola Golden 1039 W Saratoga St

15 DEC 4-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from 11/24/22, 1922 to 12/2/, 1922

that I last saw him alive on 12/2/, 1922

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. T. Howell M.D.

12/3/ 1922 (Address) 119 Carroll Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Dec 4 1922

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 1114 W. Saratoga St.

D69727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

201

D69727

Registered No. C.....27.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... John Gannon

(Residence in Baltimore: No..... New York abt. St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widow or Divorced. (Write the word.) Married

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1867 (Year)

AGE. 55 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Ship Master
(b) General nature of industry, business, or establishment in which employed (or employer). Sea

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER. (State or Country). "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER. (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John. Dept

(Address) Balto. Md.

15- DEC 4 - 1922 192... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Nov 28 ....., 192.2.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Found dead Pier 6. Pratt St
Cause undetermined

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) ..... M. D.
(Coroner)

Dec 3 192.2. (Address) 1637 Bonaparte

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Trinity Cemetery

DATE OF BURIAL. 12/4/22 19...

20-UNDERTAKER. Geo. J. Roth

ADDRESS 1135 Hanford Ave

D69728

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69728

CERTIFICATE OF DEATH

167

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 641 So. Kenwood Ave St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John Kamuda

(Residence in Baltimore. No. 641 So. Kenwood Ave St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. April (Month) 11 (Day) 1876 (Year)

7-AGE. 46 yrs. 7 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer). .....

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Anthony Kamuda

11-BIRTHPLACE OF FATHER, (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Mary Dzieken

13-BIRTHPLACE OF MOTHER, (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Kamuda

(Address) 644 So. Kenwood Ave

15. Filed DEC 4 - 1922 192..... ROBERT R. KRAUTER, Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1st (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Inhaling Illuminating Gas

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. P. O. Horton M. D.

Dec 2nd 1922. (Coroner) (Address) Curtis Bay, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary Cem — DATE OF BURIAL. Dec 7 1922

20-UNDERTAKER. Stephen J. Walbert — ADDRESS 1100 S. Kenwood Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D69729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69729

CERTIFICATE OF DEATH.

113

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3813 E. Pratt St. ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Garofalo

(Residence in Baltimore: No. 3813 E. Pratt St St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. fem

4-COLOR OR RACE. blk.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct 10, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 1 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto md.

PARENTS.

10-NAME OF FATHER, Michael Garofalo

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Ceremi Saveria

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Garofalo

(Address) 3813 E. Pratt St

15-

Filed DEC 4—1922 ROBERT R. KRAUTER, 191...
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 27th 1922, to Dec. 1st 1922 that I saw h[er] alive on Dec 1st 1922, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

acute infantile diarrhea

7

(Duration)....yrs....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) Chas. Testa M. D.

....., 191... (Address) 20 Pearl St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Sacred Heart Cem. DATE OF BURIAL, Dec 5, 1922

20-UNDERTAKER Lilly & Zirkin ADDRESS 403 S. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69730 D69730

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1842 N. Stanford Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Hainaster

(Residence in Baltimore: No. 1842 N Stanford Ave, St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, May (Month) 8 (Day), 1838 (Year)

7-AGE, 84 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Co. Md.

PARENTS.

10-NAME OF FATHER, John Coons.

11-BIRTHPLACE OF FATHER (State or Country), Balto Co Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John G. Hainaster

(Address) 1100 E 32d St

15 DEC 4-1922 Filed ....., 191.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 2 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1922, to Dec 2 1922, that I saw h[illegible] alive on Dec 2 1922, and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Dec 4, 1922 (Address) 4707 Harford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Zion Cem. Stemmers Run — DATE OF BURIAL, Dec 5, 1922

20-UNDERTAKER Lilly & Zeiler — ADDRESS 403 E. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Where CAUSE OF DEATH is very important, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D69731

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69731

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 434 N. Linwood Ave ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Barnickel (Barnickel)

(a) RESIDENCE NO. 2222 Fairmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Barnickel

6 DATE OF BIRTH (month, day, and year) March 13-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Barnickel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Zeller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address)

15 Filed DEC 4 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-1-1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 15 1922, to Dec 1st 1922,

that I last saw h alive on Dec 1st 1922,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Primary Dis of heart (Old age)

(duration) 2 yrs. 1/2 mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2222 Fairmount Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Thomas M. D.

, 19 (Address) 604 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Dec 5th 1922

20 UNDERTAKER Tilly & Zeiler

ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIANS should take CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be carefully supplied. Exact information should be

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69732

CERTIFICATE OF DEATH.

90

D69732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

2-FULL NAME Lucy Young

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address) JOHNS HOPKINS HOSPITAL

15 DEC 4-1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

340

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1922

17 I HEREBY CERTIFY, That I attended deceased from October 23, 19 22, to November 30, 19 22, that I last saw her alive on November 29, 19 22, and that death occurred, on the date stated above, at 7:00 A.M. The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde O'Neil, M. D.

12/1/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS DEC 4-1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. See instructions on back of certificates. Information is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69733

CERTIFICATE OF DEATH.

D69733

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Manning

(a) RESIDENCE NO. 530 Greenwillow st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Manning

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address) Municipal Tuberculosis Hospital

15 Filed DEC 4 1922 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1922, to Nov. 28, 1922, that I last saw him alive on Nov. 28, 1922, and that death occurred, on the date stated above, at 8.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Sidoplucella, M. D.

11-29-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health.

DEC 4 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

3/0

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

D69734

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 Boyd ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edw Jackson

(a) RESIDENCE. NO. 932 Boyd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Mar.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stowman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sadie Jackson
(Address) 932 Boyd St

15 DEC 4 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1922, to Nov 29, 1922, that I last saw h alive on Nov 29 1922 3:30 p, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Paresis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

, 19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL Dec 4 1922

20 UNDERTAKER Wood Easton Co ADDRESS 916

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69735 CERTIFICATE OF DEATH. 159-002 Registered No. C.....

D69735

1-PLACE OF DEATH

City of BALTIMORE: (No. 1143 Woodyear St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Baby Daniels

(Residence in Baltimore: No. 1143 Woodyear St. St.; yrs. 1/2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	S

6-DATE OF BIRTH. Dec. 1 (Month) (Day) 1922 (Year)

7-AGE. ....yrs....mos....ds. If LESS than 1 day, 7½ hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....none.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Infant.....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Nelson Daniels

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Sally Robinson

13-BIRTHPLACE OF MOTHER, (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nelson Daniels

(Address) 1143 Woodyear St.

15-DEC 4-1922 Filed..... 192..... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 1 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prem. Premature Infant

7½ hrs.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs....mos....ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

Dec. 3 1922 (Address) 2302 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
HOPKINS HOSPITAL	....., 19....
20-UNDERTAKER.	ADDRESS. DEC 4 1922
Commissioner Health.	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

390

15703

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69736

107-003

D69736

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital (St.) 7 (Ward) (Slaich)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rose Sleich

(a) RESIDENCE. No. 932 Lexington St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of Wm Sleich

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 36 Mo..ths Days If LESS than 1 day, hrs. or min

8 OCCUPATION OF DECEASED: Tobacco Worker.

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Morals

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Anna Milan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): John Morals 922 Eastern Ave

15 DEC 4 - 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2 19 22

17 I HEREBY CERTIFY, That I attended deceased from Nov 12 19 22 to Dec 2 19 22

that I last saw her alive on Dec 2 19 22

and that death occurred, on the date stated above, at 5.10 a.m.

The CAUSE OF DEATH* was as follows: Cardiac Failure

8 weeks (duration) mos. ds.

CONTRIBUTORY (Secondary): Septicemia Pneumonia Diabetes (duration) mos. ds.

18 Where was disease contracted if not at place of death? at home ?

Did an operation precede death? yes Date of 11/7 22

Was there an autopsy? No

What test confirmed diagnosis? Blood culture Pneumococcus

(Signed) Dr. Greenberg, M. D.

19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Dec 6 19 22

20 UNDERTAKER: Gust Croxton

ADDRESS: 1716 Eoblon

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIANS should BE SURE that information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69737

CERTIFICATE OF DEATH.

86-001 D69737

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah White

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	75	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records. (Address)

15 DEC 4 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from October 28, 1921, to December 3, 1922.

that I last saw her alive on December 2, 1922.

and that death occurred, on the date stated above, at 4:05 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. L. McNeil M. D.

12/4/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 12/4 1922

20 UNDERTAKER Samuel G. Greenberg

ADDRESS 478 N. Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69738 90 D69738

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 Valley ST.: 10 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen C. Duffy

(a) RESIDENCE. No. 518 E. Eager ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Duffy

6 DATE OF BIRTH (month, day, and year) Mar. 12, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	8.	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Mathew Kernan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Kemptel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Miss Mary Kernan 518 Eight Eager St

15 Filed DEC 4 - 1922 19 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1922 to Dec 2, 1922

that I last saw h Cr alive on Dec 2, 1922

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Failure of Compensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no (Private)

What test confirmed diagnosis?

(Signed) J. Walter Thomas, M. D.

Dec 3 1922 (Address) 1228 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bonnie Brae Cemetery	Dec 5 1922
20 UNDERTAKER	ADDRESS
E. W. Conklin	924 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should give information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

D69739

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D69739

REGISTERED No. C

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 1408 Eutaw Place ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Caroline Lloyd Starr

(Residence in Baltimore: No. 1408 Eutaw Pl.

60 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ? (Month) ? (Day) 1? (Year)

7-AGE, 70 ? yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lady at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Robert Y. Starr

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Caroline Lloyd.

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Frank V. Meade

(Address) 1417 Linden Ave

15-

1922 ROBERT S. KRAUTER,

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 2, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said — (Inquest, autopsy or inquiry.) Gastritis find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of hip
Pneumonia
(Duration) yrs. mos. 4 3 ds.

CONTRIBUTORY (Secondary) Bronchi-Pneumonia
(Duration) yrs. mos. 3 ds.

(Signed) J. T. Hemmeter M. D.
(Coroner.)

Dec 4, 1922 (Address) 2512 Guilford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Belmont Cem	Dec. 4, 1922

20-UNDERTAKER	ADDRESS
Henry J. Jenkins & Son Co.	Oakland Mc Collon St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69740

D69740

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 70 WARD)

2-FULL NAME Mr. Frank Hoddinott

(a) RESIDENCE NO. 1937 Edmonson Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Hoddinott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Birchnall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Oliver M Hoddinott
(Address) 1937 Edmonson ave

15 Filed 4-, 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1922, to Dec 2, 1922, that I last saw him alive on Dec 2, 1922, and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symp. & Phy. Signs

(Signed) Daniel J. Pessagno, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 6th 1922
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 E Monument

C. N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

D69741

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69741

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 737 So. Broadway St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Chmielewski

(Residence in Baltimore: No. 215 So. Collington ave St.; 41 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Unknown ..... 1..... (Month) (Day) (Year)

7-AGE: about 42 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Poland

PARENTS.

10-NAME OF FATHER: Jacob Chmielewski

11-BIRTHPLACE OF FATHER, (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Frances Henez

13-BIRTHPLACE OF MOTHER, (State or Country): Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adam Michalak

(Address) 215 S. Collington Ave

15- Robert P. Harrison,

DEC 4 1922

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2nd (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

about 4 days (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) Thos B. Norton M. D.
Coroner.

Dec 3rd 1922 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St. Stanislaus Cem.	Dec 7 1922
20-UNDERTAKER. W. F. Sadowski.	ADDRESS. 405 S. Ann St.

NOTICE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69742 D69742

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 N. Monroe ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise C. Riter

(a) RESIDENCE. No. 212 N. Monroe ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John B Riter

6 DATE OF BIRTH (month, day, and year) March 4 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Christian F. Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Wilhelmina Romig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Wilhelmina Klein 212 N. Monroe St.

Robert F. Griffith, Registrar

Dec 4 1922, 19

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1922.

17 I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ Nov 27 1922, to Dec 3 1922, that I last saw h alive on Dec 2 1922, and that death occurred, on the date stated above, at 12:30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary & Laryngeal Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A Geary, M. D.

, 19 (Address) 101 N. Geary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Dec 5 1922

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave

CB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

(See Letter attached) ✓

D69743 HEALTH DEPARTMENT—CITY OF BALTIMORE D69743

CERTIFICATE OF DEATH. 188-003 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hosp. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H. Garner

(~~Residence in Baltimore:~~ No. Colgate P.O. Balto Co Md St.; yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or ~~Divorced.~~ (Write the word.) Married

6-DATE OF BIRTH. (Month) (Day) 1889 (Year)

7-AGE. ~~40~~ 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer). Farm

9-BIRTHPLACE. (State or Country). Anne Arundel Co

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER. (State or Country). —

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER. (State or Country). —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. B. Stengle (Employer)

(Address) Colgate P.O. Md.

15- Filed Nov 4 1922 Robert P. Harrison, Registrar.

~~Burial Permit Clerk.~~

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov (Month) 30 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Subdermal Hemorrhage
Automobile overturned on
wheel he was riding & he
was pinned under same (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. H. Waller M. D. (Coroner.)

Dec 3 1922 (Address) 508 E. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (I) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cem. DATE OF BURIAL. Dec 5 22

20-UNDERTAKER. Clark W. Johnson ADDRESS 416 N Caroline St.

C. N. 8—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C 4—1922

508 NORTH AVENUE, EAST
BALTIMORE, MARYLAND

December 5/92

Health Dept.
Registrar of Vital Statistics
Dear Sir:- Please correct in dest
certificate of Wm H. Garrett Colored
the age from 40 yrs to 33 yrs.
I was misinformed by Mr Kinyon
he was born in 1859.

Respectfully
J. H. Allen M.D.
Corner Northwestern Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69744

CERTIFICATE OF DEATH.

74-001 D69744

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 N Caroline ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M Lauister

(a) RESIDENCE NO. 420 N Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept 17 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: J. David Lauister

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Kuhlman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Laura E Lauister

(Address): 420 N Caroline

15 Robert P. Carter, 19

Burial Permit Clerk. Registrar

DEC 4-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Dec 3, 1922, that I last saw him alive on Dec 2, 1922, and that death occurred, on the date stated above, at 2:04 m.

The CAUSE OF DEATH* was as follows:

arterial Sclerosis

duration 2 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. T. Mitchell, M. D.

, 19 (Address) 700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Dec 5 1922

20 UNDERTAKER: Henry Lutz — ADDRESS 1203 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69745

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69745

CERTIFICATE OF DEATH.

162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 St Helena ave ST.; 26 WARD)

2-FULL NAME James Magann

(a) RESIDENCE. No. 311 St Helena ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 26 1922

7 AGE — Years — Months 6 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John S. Magann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Marie E. Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John S. Magann
(Address) 311 St Helena ave

15 Filed . 19 . Registrar

DEC 4 - 1922

Robert F. Carraher
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1922, to Dec 2, 1922, that I last saw h[illegible] alive on Dec 1, 1922, and that death occurred, on the date stated above, at 9-30 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumatosis cystoides

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

12/2, 1922 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Dec 4 1922

20 UNDERTAKER: Geo. J. Rubb — ADDRESS: 1735 Hanford ave

over.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69746

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69746

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 N Montford Ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida L Brooks

(a) RESIDENCE NO. 1115 N Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 9th 1921

7 AGE: Years 1 | Months 6 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James D Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Rosa F Maguire

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): James Brooks 1116 N Montford ave

15 DEC 4 1922, 19 Robert E. Lee Platt, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 3rd 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 , 19 22 , to Dec 3 , 19 22 ,

that I last saw h alive on Dec 2 , 19 22 ,

and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Tetanus Umbilicus

(duration) 2 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery. DATE OF BURIAL: Dec 5th 1922

20 UNDERTAKER: Robt F Turner Jr. ADDRESS 1442 W Broadway

N. B.—WRITE PLAINLY, WITH ONE ADDING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be careful and state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Blks.

D69747

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69747

CERTIFICATE OF DEATH. 100-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 N Chapel St ST., 8 WARD)

2-FULL NAME Charles F Mueller

(a) RESIDENCE NO. 1806 N Chapel St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): July 5th 1918

7 AGE — Years: 4 — Months: 5 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Fred. Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Fred Mueller

(Address): 1806 N Chapel St

1920 Filed ..... 19 .....

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 2 1920

17 I HEREBY CERTIFY, That I attended deceased from November 29 1920 to December 2 1920, that I last saw him alive on December 2 1920, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. over mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) D. Gilbert Linganore M. D.

12/3/ 1920 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec 4th 20

20 UNDERTAKER: Robt J Turner Inc — ADDRESS 1442 N Broadway

20 B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69748 D69748

CERTIFICATE OF DEATH.

X 44

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. Page

(a) RESIDENCE. NO. Charlestown W. Va. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 4 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Page

6 DATE OF BIRTH (month, day, and year) July 10th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
63yrs.		4	24	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farming.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER George Page

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Elizabeth Page

(Address) Charlestown W. Va.

15 Dec 5 1922 Robert P. Hatton, Burial Permit Clerk. Registrar

DEC 4 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-4 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30 1922 to Dec-4th 1922 that I last saw h[illegible] alive on Dec-4th 1922 and that death occurred, on the date stated above, at 10.20 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) Two yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Dec-1st

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) H. H. Jones M. D.

12/4 1922 (Address) Johnsey Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlestown W. Va.	Dec 5 1922
20 UNDERTAKER	ADDRESS
Mr. Mrs John W. Teufel & Son	501 N. Fayette

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69749

D69749

CERTIFICATE OF DEATH.

10

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Glenolden ST., 16 WARD)

2-FULL NAME Willie E Leamann.

(a) RESIDENCE NO. 616 Glenolden. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	2	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER James E Leamann

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Eva M. Davis

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant James E Leamann.
(Address) 616 Glenolden Ave.

15 Dec 4 1922 Robert P. [illegible] 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4. 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1922, to Dec 4, 1922, that I last saw h.. alive on Dec 4, 1922, and that death occurred, on the date stated above, at 12. noon, m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. One ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Culture

(Signed) J. M. Lampmann M. D.

Dec 4 1922 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Dec 5th 1922

ADDRESS

20 UNDERTAKER Wm. H. Smith & Son

ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should see that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should see that information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

DEC 4 1922

D69750

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69750

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1741 E. Lombard St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Rincke

(Residence in Baltimore: No. 1741 E. Lombard St.; yrs. 7 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Unknown 18.6.
(Month) December (Day) 19 (Year)

7-AGE. About 56 yrs. ## mos. ## ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of Industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE, (State or Country). Mass

PARENTS.

10-NAME OF FATHER. James Cassidy

11-BIRTHPLACE OF FATHER, (State or Country). Orland

12-MAIDEN NAME OF MOTHER. Mary Hogan

13-BIRTHPLACE OF MOTHER, (State or Country). Orland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Zoughez

(Address) 1741 E. Lombard St.

15 DEC 4 1922

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1st, 192.2
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. B. Horton M. D.
Coroner.

Dec 1 1922 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Adams (Massachusetts)

DATE OF BURIAL. Dec 5 1922

20-UNDERTAKER. Newell Wappel Son

ADDRESS 3138 Mon

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1644

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69751

CERTIFICATE OF DEATH.

REGISTERED No. C 90 D69751

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4224. Park Heights St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H Kriener

(Residence in Baltimore: No. 4224. Park Heights St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, August 24th, 1890
(Month) (Day) (Year)

7-AGE, 32 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) 030

9-BIRTHPLACE, (State or Country), Toledo Ohio

PARENTS.

10-NAME OF FATHER, Anthony P. Kriener

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Anna Scheuer

13-BIRTHPLACE OF MOTHER (State or Country), Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. G. Kriener

(Address) 4224 Park Heights

15- Filed DEC 5 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 1, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (or post-mortem examination, or inquiry.) thereon and from the evidence obtained at said Inquest, as per Inquest (or post-mortem examination, or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner.)

, 191... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Toledo Ohio

DATE OF BURIAL, Dec 4, 1922

20-UNDERTAKER Lowe Cook

ADDRESS 50 E Mouch

c/o Mrs. G. Kriener; Via Boo Kk.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Spec. 1-10 21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69752

CERTIFICATE OF DEATH.

90

REGISTERED NO. D69752

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2875 N. Lanvale St. (Ward) 16

2-FULL NAME John Friedknecht

(a) RESIDENCE No. 2875 N Lanvale St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Roselle Friedknecht

6 DATE OF BIRTH (month, day, and year) Sept 1-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER ? Zulreich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Louise Gort

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Lorette Friedknecht

(Address) 2875 N Lanvale

15 Filed DEC 5 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1922 to Dec 4, 1922

that I last saw him alive on Dec 4, 1922

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Decompensation)

(duration) yrs. mos 2 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) J. H. Zerbe, M. D.

1923 19 (Address) 1103 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL 12/1 19

20 UNDERTAKER Wm Cook

ADDRESS 502 N Mt

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69753

CERTIFICATE OF DEATH.

65-002 D69753

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (NO. Lombard & Jessup ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Kastru

(a) RESIDENCE. NO. 1640 Darley Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) 609

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Kastru

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Dieker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) D. M. Brown 1627 Darley Ave

15 Filed DEC 5 - 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/4 1922

17 I HEREBY CERTIFY, That I attended deceased from 3/21, 1922, to 12/4, 1922; that I last saw him alive on 12/4, 1922, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Hodgkin's Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy & clinical

(Signed) Iron Sheldon M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emanuels Cem

DATE OF BURIAL 12/7 1922

20 UNDERTAKER Wm Cook

ADDRESS 501 E Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69754

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 44 D69754

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME Thomas Williams

(a) RESIDENCE NO. Bowie, Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) June 10 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Washington (State or country) D. C.

PARENTS

10 NAME OF FATHER Thos. Williams

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Moriah Tyler.

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mercy Hospital Records (Address)

15 Date DEC 5 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1922, to Dec. 4, 1922.

that I last saw him alive on Dec. 4, 1922,

and that death occurred, on the date stated above, at 2.25 P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy? .....

What test confirmed diagnosis? Symptoms & Signs

(Signed) J. F. Savage M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bowie Md.

DATE OF BURIAL 12/5 1922

20 UNDERTAKER Edward B Hardy.

ADDRESS 1[illegible] [illegible] St. West

Spec. 6-9-19 H.P.C. 1000 Blks.

D69755

HEALTH DEPARTMENT—CITY OF BALTIMORE D69755

CERTIFICATE OF DEATH.

REGISTERED NO. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2215 Elsinore Av ST.: 15 WARD)

2-FULL NAME William H Tarbell

(a) RESIDENCE. No. 2215 Elsinore Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~WIFE~~) Loretta M. Tarbell

6 DATE OF BIRTH (month, day, and year) June 2, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

066

9 BIRTHPLACE (city or town) (State or country) St Louis Mo

PARENTS

10 NAME OF FATHER John Tarbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mrs Loretta M. Tarbell
(Address) 2215 Elsinore Av

15 DEC 5 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24 1922, to Dec 3 1922, that I last saw him alive on Dec. 2 1922, and that death occurred, on the date stated above, at 6.10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Syphilis (Remote) (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Physical signs

(Signed) Charles Ecs M. D.

Dec 4 1922 (Address) 1111 N. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: Dec 5 1922

20 UNDERTAKER: Chas. E. Franck — ADDRESS: 801 Madison Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69756

CERTIFICATE OF DEATH.

90 D69756

REGISTERED NO.

1-PLACE OF DEATH Hebrew orphan Home for Aged & Infirm (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2100 E. Baltimore Street ST., 6 WARD)

2-FULL NAME Esther Shepiro

(a) RESIDENCE NO. 4 N. Chester Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Dave Zelig Shepiro

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	78	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Old age
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Elza Yaffie
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Unkown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Balto St

15 Filed DEC 5 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/4 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1922, to Dec. 4, 1922,
that I last saw her alive on Dec. 4, 1922,
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Max J. Baylin M. D.
12/5, 1922 (Address) 210 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 12/5 1922.

20 UNDERTAKER Jack Lewis 1439 E Balto — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69757

74-001 D69757

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2100 E Baltimore

CITY OF BALTIMORE: (No. Hebrew Nyd Hemp Ln Cemetery ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Paul Mofsowitz

(a) RESIDENCE NO. 2301 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Esther Mofsowitz

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 62 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

045

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Max Mofsowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Leah Linder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address) 1439 E Balto St

15 Filed DEC 5 - 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/4 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1922, to Dec 4, 1922, that I last saw h[illegible] alive on Dec. 4, 1922, and that death occurred, on the date stated above, at 6 0 m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Hemaplegia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): redness of lungs

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M J Baylin, M. D.

12/4, 1922 (Address) 210 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Woodlawn Rd

DATE OF BURIAL: 12/5 1922

20 UNDERTAKER: Jack Lewis 1439 E Balto

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69758

CERTIFICATE OF DEATH.

9- D69758

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 East Church ST. 22 WARD)

2-FULL NAME Mamie Marks

(a) RESIDENCE NO. 128 East Church ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 9- 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not any

(b) General nature of industry, business, or establishment in which employed (or employer) — —

(c) Name of employer — —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Marks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mamie Binecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Mamie Marks
(Address) 128 E Church St

15 FILED DEC 5-1922 Burial Permit Clerk. NURSE. M. ARAJILI, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1922

17 I HEREBY CERTIFY, That I attended deceased from November 12, 1922, to Dec 4 - 1922,

that I last saw her alive on Dec 4 - 1922,

and that death occurred, on the date stated above, at 5- P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Enteritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) E E Sutton M. D.

12/4. 1922 (Address) 301 E Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL Dec 5 1922

20 UNDERTAKER John F Denny

ADDRESS 715 L St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D69759

REGISTERED NO. D69759

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D69759

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 N. Central Ave. ST., 9 WARD)

2-FULL NAME Adam Dressel

(a) RESIDENCE NO. 1313 N. Central Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs. Maria Dressel

6 DATE OF BIRTH (month, day, and year) July-18-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Telegraph Operator

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Leonard Dressel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Seippel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dr. Leonard Dressel (Address) 1313 N. Central Ave.

15 Filed DEC 5 - 1922, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec.-3-1922

17 I HEREBY CERTIFY, That I attended deceased from December 2 to December 3 19 22

that I last saw him alive on December 3 19 22

and that death occurred, on the date stated above, at 5:05 P. M.

The CAUSE OF DEATH was as follows:

1 Apoplexy Cerebral Hemorrhage

2 Aged age 80 yrs. 4 mos 15 ds.

3 Hemiplegia (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

Were findings considered in determining diagnosis? Clinical

(Signed) Wm. R. A. Meyer, M. D.

12/4 19 22 (Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Dec. 6 19 22

20 UNDERTAKER: Henry Storck & Son ADDRESS 1308 E. Eag-4

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69760

CERTIFICATE OF DEATH.

161-001 D69760

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hosp. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mulcahy

(a) RESIDENCE NO. Parkville Balto Co. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, ~~or Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Dec 3, 1922

7 AGE — Years: — Months: Days: 1 If LESS than 1 day, 15 hrs or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Thomas Mulcahy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: M. E. Kimlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt Co.

14 Informant: Thomas Mulcahy. (Address): Parkville. Balto co

15 Filed DEC 5 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3 .1922. to Dec. 4 .1922.

that I last saw him alive on Dec. 4 .1922.

and that death occurred, on the date stated above, at 6.45 a m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Congenital birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. C. Irwin, M. D.

. 19 (Address) 4706 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Joseph Cemetery — DATE OF BURIAL: Dec 6 1922

20 UNDERTAKER: Geo. J. Rutter — ADDRESS: 1735 Harford Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69761 D69761

CERTIFICATE OF DEATH.

159-002

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West End Maternity Hosp. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Clara Gaver

(Residence in Baltimore: No. 2610 Cleveland Ave St.; ....yrs., ...mos. 3 ds.)

West End Maternity

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem.	W.	

6-DATE OF BIRTH, 12-1-22 (Month) (Day) 1922 (Year)

7-AGE, ...yrs. ....mos. 2½ ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Joseph Gaver

11-BIRTHPLACE OF FATHER (State or Country), Middletown Md.

12-MAIDEN NAME OF MOTHER Billie Ryan

13-BIRTHPLACE OF MOTHER (State or Country), Cincinnati Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. R. Stromberger R.N.

(Address) 112 N. Calhoun St.

15-

DEC 5 - 1922 ROBT. R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 4 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1922, to Dec. 4 1922, that I saw h er alive on Dec. 4 1922, and that death occurred, on the date stated above, at 12 p.m.

The CAUSE OF DEATH* was as follows:

Premature Labor - Congenital

Premature - Failure Closing

Pneumonia Double

(Duration) ....yrs. ....mos. 3 ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) C. H. Beeton M. D.

12-4, 1922. (Address) 1st Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL. New Market Md. DATE OF BURIAL, Dec 5, 1922

20-UNDERTAKER P S Marshall ADDRESS 3839 Falls Rd.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69762

CERTIFICATE OF DEATH.

90 D69762

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1339 Sargeant St.: 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Rollins

(a) RESIDENCE. No. 1339 Sargeant St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John F. Rollins

6 DATE OF BIRTH (month, day, and year): 1-4-1865

7 AGE: Years 57; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Bohlayer

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Margaret Reinhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Chas. Smith

(Address): 1339 Sargeant

15 FILED DEC 5 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 30th 1922, to Dec 4th 1922, that I last saw her alive on Dec 4th 1922, and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Embolism

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) L. McCorkle, M. D.

Dec 4, 1922 (Address) 1114 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Dec 7 1922

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Nath

D69763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

700-001 D69763

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 715 N Eden St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Reid

(Residence in Baltimore: No. Mott (Mt Hope & Eden) St.; yrs. 2 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.): S

6-DATE OF BIRTH: Sept (Month) 3 (Day) 1874 (Year)

7-AGE: 48 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): D H D

9-BIRTHPLACE, (State or Country): Va

PARENTS.

10-NAME OF FATHER: Warren Reid

11-BIRTHPLACE OF FATHER, (State or Country): Va

12-MAIDEN NAME OF MOTHER: Sarah Smucker

13-BIRTHPLACE OF MOTHER, (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Cath R Elliott

(Address) 725 Ashland Ave

15- Filed DEC 5 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 3 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Collins M. D. (Coroner.)

12-5 1922 (Address) 508 E Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Dec 5, 1922

20-UNDERTAKER, Mrs R C Elliott — ADDRESS 1223 Ashland Ave

Spec.—1-10-21—M&T—1500 Blks.

D69764

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D69764

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1700 W. Lexington St. ST. 19 WARD)

2-FULL NAME Mary A. Newton

(a) RESIDENCE NO. 1700 W. Lexington St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George E. Newton

6 DATE OF BIRTH (month, day, and year) June 5th 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Bodden

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth R. Baker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant G. E. Newton (Address) 1700 W. Lexington St.

15 Filed DEC 5 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1922, to Dec - 2, 1922, that I last saw h. alive on Dec - 2 -, 1922 and that death occurred, on the date stated above, at 11.30 A.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency of Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Martin W Stork, M. D.

12/2/1922 (Address) 806 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 5th 1922
20 UNDERTAKER Enoch B Cook	ADDRESS 1003 W Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67 D69765

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 421 S. Smallwood ST., 70 WARD)

2-FULL NAME Anton Bock

(a) RESIDENCE NO. 421 S. Smallwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 2 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	19	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paint mixer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Davis Paint Co.

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Adam Bock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Anna Emory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Adam Bock (Address) 421 S. Smallwood St.

15 Filed DEC 5 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 2 1922, to Dec 3 1922, that I last saw him alive on Dec 3 1922, and that death occurred, on the date stated above, at 10.15 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? own

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. O'Neill M. D.

12/4 1922 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Dec 6th 1922

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Lead Poisoning

Spec.—1-10-21—M&T—1500 Bks.

D69766

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D69766

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 18 WARD)

2-FULL NAME Geo H. Jackson

(a) RESIDENCE NO. 512 Stockton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula Jackson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED Steamfitter

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) St Marys Co Md

(State or country)

PARENTS

10 NAME OF FATHER Robert Jackson

11 BIRTHPLACE OF FATHER (city or town) St Marys Co

(State or country) Md

12 MAIDEN NAME OF MOTHER Jane —

13 BIRTHPLACE OF MOTHER (city or town) St Marys Co

(State or country) Md

14 Informant Lula Jackson

(Address) 512 Stockton St

15 Filed DEC 5 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 4, 1922

that I last saw h— alive on Dec 4, 1922

and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Evidence

(Signed) Dr. J. Bruce Gray M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakville. St Mary Co. Md

DATE OF BURIAL Dec 6 1922

20 UNDERTAKER Katie R. Williams

ADDRESS 1114 N. Saratoga St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69767

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69767

CERTIFICATE OF DEATH.

1-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3044 Greenmount Ave ST., 17 WARD)

2-FULL NAME Daniel Bowman Dehuff.

(a) RESIDENCE NO. 317 E. Lanvale St., ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Angeline Dehuff (nee Foust)

6 DATE OF BIRTH (month, day, and year) Oct. 18, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	I	I4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Master Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Penn R R

(c) Name of employer Penn R R

9 BIRTHPLACE (city or town) York Co.,
(State or country) Pa.,

PARENTS

10 NAME OF FATHER William Dehuff

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Pa.,

12 MAIDEN NAME OF MOTHER Elizabeth Bauman

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Pa.

14 Informant Mrs. Seth Duff
(Address) 2506 Guilford Ave.

15 DEC 5-1922 RUTH R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 10th, 1922, to Dec 30th, 1922, that I last saw him alive on Dec 30th, 1922, and that death occurred, on the date stated above, at Dec 2nd a.m.

The CAUSE OF DEATH* was as follows:

Acute dilation of Right heart caused by sudden strain.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Infection Myocarditis due to Typhoid fever (duration) yrs. Oct 10th mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Ex. of Heart on Oct 10th

(Signed) Amelia V. Zimmerman, M. D.

Dec 2 1922 (Address) 1805 W North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Dec. 5 19 22

20 UNDERTAKER Harry H. Witzke

ADDRESS 1531 W Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Abraham Kabik)

D69768

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D69768

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No.) Rutland Ave + Maynard St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Kabik

(a) RESIDENCE. No. Fayette + North Ave Forks Hosp. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? 16 yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 82 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Jacob Kabik

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Nathan Kabik 1528 Smallwood

15 Filed DEC 5 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5 1922

17 I HEREBY CERTIFY, That I attended deceased from 11/28, 1922, to 12/5, 1922, that I last saw him alive on 12/5, 1922, and that death occurred, on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholecystitis, Chr Nephritis, Hypocard. Long Standing (duration) yrs. mos. ds.

18 WHere was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Adler Smallwood M. D.

12/5, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale Cmet — DATE OF BURIAL: 12/5 1922

20 UNDERTAKER: Max Levinson — ADDRESS 1127 E. Baltimore St

Spec.—1-10-21—M&T—1500 Blks.

D69769

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69769

CERTIFICATE OF DEATH.

REGISTERED NO. 88

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Whitten

(a) RESIDENCE NO. 1144 N. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of Mamie ~~Whitten~~ Gregory

6 DATE OF BIRTH (month, day, and year) Sept 15 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain - Ingboat

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Whitten

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Barbara Arbhoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed DEC 5 1922 ROBERT R. KRAUTER, [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3 - 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1922, to Dec 3, 1922, that I last saw him alive on Dec 3, 1922, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Subacut Bacterial Endocarditis (Streptococcus Viridans)

(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Chas. W. Cumming M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Dec 7 1922

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16018 D69770 — 129 — D69770

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST., 10 WARD)

2-FULL NAME Colbright Dell Brown

(a) RESIDENCE NO. 720 N. Caroline St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jessie Brown

6 DATE OF BIRTH (month, day, and year) Sept 6-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 59

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John Hopkin Hospital

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Date DEC 5-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 29, 1922, to Dec 4, 1922

that I last saw h[illegible] alive on Dec 4, 1922,

and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Myocardial insufficiency

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Otto R. Krug, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery. DATE OF BURIAL Dec 7 1922

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D69771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D69771

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 S. Charles ST. 23 WARD)

2-FULL NAME Mary J. Taylor.

(a) RESIDENCE NO. 1414 S. Charles ST., 23. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late William H, Taylor.

6 DATE OF BIRTH (month, day, and year): Jan. 15, 1840.

7 AGE — Years: 82. Months: 9. Days: 19. If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Delaware.

PARENTS

10 NAME OF FATHER: Henry C. Carter.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware.

12 MAIDEN NAME OF MOTHER: Charllote Jones.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Delaware.

14 Informant: Hannah S. Taylor.
(Address): 1414 S. Charles ST.

15 Filed: DEC 5-1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1/22, 19.. to Dec 4, 1922.

that I last saw h/ alive on Dec 4, 1922,

and that death occurred, on the date stated above, at 5 30 a.m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis myocarditis
Chronic interstitial nephritis
Senility

(duration) .... yrs. 4 mos. .... ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) .... yrs. .... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? symptoms

(Signed) Jas Woodnell M. D.

12/4, 1922 (Address) 1070 West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Hall, Md. Wesley Chapel Cemtery — DATE OF BURIAL: Dec. 6 1922.

20 UNDERTAKER: Mrs. J. E. Evans & Sons — ADDRESS: #1428 S. Charles St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69772 CERTIFICATE OF DEATH. 129 D69772

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Jones

(a) RESIDENCE NO. 713 S. Decker Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: Years 53; Months --; Days --; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): York, Pa.

PARENTS

10 NAME OF FATHER: James McKnew

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Mary Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co. Maryland

14 Informant: Municipal Hospital Records.

(Address)

15 Filed DEC 5-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 4 1922

17 I HEREBY CERTIFY, That I attended deceased from November 25 1922 to December 4 1922, that I last saw her alive on December 3 1922, and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clin. Path. B.P. etc

(Signed) [signature] M. D.

12/4/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec 6 1922

20 UNDERTAKER: [signature] — ADDRESS: 221 Bway

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69773 161-001 D69773

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2031 N. Boyd ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nauseda M. Dinler

(Residence in Baltimore: No. 2031 N. Boyd St ..... St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, Dec. 4th, 1922. (Month) (Day) (Year)

145 P.M.

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or 3 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), 2031 N. Boyd St

PARENTS.

10-NAME OF FATHER, John C. Dinler

11-BIRTHPLACE OF FATHER (State or Country), Balto., Md

12-MAIDEN NAME OF MOTHER Evelyn M. Paddicord

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Evelyn M. Dunler

(Address) 2031 N. Boyd St

15-

Filed ..... Robert F. Harrison ..... Registrar.

DEC 5-1922

391

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 4, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 4 - 1922, to Dec 4 1922, that I saw her alive on Dec. 4 - 1922 and that death occurred, on the date stated above, at 1.50 p. m.

The CAUSE OF DEATH* was as follows:

(a) ..... Premature Delivery

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) 5 minutes

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. K. Nuckols M. D.

Dec. 4, 1922 (Address) 130 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 191...
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner of Health.
DEC - 1922

Spec.—1-10-21—M&T—1500 Bks.

D69774

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D69774

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hosp ST., 13 WARD)

2-FULL NAME Clarence Estendorf

(a) RESIDENCE NO. 2835 Penna Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 4 mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 17 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Clarence Jones

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Vera Estendorf

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant

(Address)

15 Filed DEC 5 1922 . 19 Robert F. Carrick, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1922, to Dec 3, 1922, that I last saw him alive on Dec 2, 1922, and that death occurred, on the date stated above, at 5 30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic intestinal indigestion

(duration) 0 yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (terminal)

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm S Thayer, M. D.

, 19 (Address) 1002 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

DEC 5 - 1922

MARGIN RESERVED FOR BINDING. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 5 1922

3 12

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Lic D69775
Balto is not Highland ave

CERTIFICATE OF DEATH. 31 D69775

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 124 N. 10th ST., (or WARD) 26

2-FULL NAME Charles Edward Smith.

(a) RESIDENCE NO. 124 N. 10th ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. 11 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederickea A. Smith.

6 DATE OF BIRTH (month, day, and year) Dec. 15th 1890

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
31	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oiler at Contenental

(b) General nature of industry, business, or establishment in which employed (or employer) Can Co. 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Smith.

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Anna Lang.

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Frederickea A. Smith (wife)

(Address) 124 N. 10th St.

15 Dec 5 1922 Robert P. Harris, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3rd 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 23, 1922, to Dec 3, 1922, that I last saw him alive on Dec 3, 1922, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) Perforation of Ileum

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Mt Hope

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Widal

(Signed) J. W. Schryver, M. D.

12/3, 1922 (Address) 330 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Dec 6th 1922

20 UNDERTAKER Lilly & Zeiler ADDRESS 400 S. Wolfe

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69776 88 D69776

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1912 Bauls ST.: 2 WARD)

2-FULL NAME John Traule Deckert.

(a) RESIDENCE. NO. 1912 Baule ST., 2 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 11 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 14th 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Paul Deckert.

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Josephine E. Remlein

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant (Josephine E. Deckert (mother)
(Address) 1912 Bauls St.

15 Filed 1922, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 5 - 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1922, to Dec 5th, 1922, that I last saw h[illegible] alive on 5th, 1922, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Uremic Convulsion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Nephritis over

" (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Winner, M. D.

12-5, 1922 (Address) 30 S. 13th way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cem	Dec 8th 1922
20 UNDERTAKER Lilly + Zeiler	ADDRESS 4008 Wolfe

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

12-5-1922

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Streptococcus infection which caused endocarditis.

D69777

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D69777

X 129

REGISTERED NO. C

1-PLACE OF DEATH

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 416 E Chase ST.: 10 WARD)

2-FULL NAME Catherine Haggerty

(Residence in Baltimore: No. 416 E Chase St.: yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: ? (Month) (Day), 1850 (Year)

7-AGE: 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Private 070

9-BIRTHPLACE (State or country): Cumberland Md

PARENTS

10-NAME OF FATHER: Patrick Haggerty

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Mary O'Shea

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daniel Haggerty

(Address) 2138 N Whalleywood

15- Dec 5 - 1922 Robert P. Harrison, Burial Permit Clerk. 191 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 4 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 4 1922 to Dec 4 1922

that I saw h- alive on Dec 4 1922

and that death occurred, on the date stated above, at 11 40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 12 yrs. mos. ds

Contributory (SECONDARY): Oedema of Lungs

(Duration) yrs. mos. 3 hrs

(Signed) James M Routson M. D.

Dec 5 1922 (Address) 700 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.
At place of death							
Where was disease contracted, if not at place of death?							
Former or usual residence							

19-PLACE OF BURIAL OR REMOVAL: Cumberland Md

DATE OF BURIAL: Dec 6 1922

20-UNDERTAKER: W M Routson

ADDRESS: 2258 N North

B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69778 HEALTH DEPARTMENT—CITY OF BALTIMORE 188-003 D69778

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Josephs Hosp St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Mary L Cain

(Residence in Baltimore: No. 2133 Taylor Av St.; yrs., 38 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. April 16, 1867 (Month) (Day) (Year)

7-AGE. 55 yrs. 7 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At Home
(b) General natnre of industry, business, or establishment in which employed (or employer). 31

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. Edward Burke

11-BIRTHPLACE OF FATHER, (State or Couutry). Ireland

12-MAIDEN NAME OF MOTHER. Margaret Maloney

13-BIRTHPLACE OF MOTHER, (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah J. Deal (Sister)

(Address) 2133 Taylor Av

15- Robert P. Harrison, 192.... Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified.—Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 5 1922

Daniel Ferrell Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 4 192.2 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by Automobile on Dec 4, 22.
Fracture Skull & Lt Clavicle
Shock
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Investigation by the Coroner Dec 6/22 8:30 am
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Collins M. D. (Coroner.)

Dec 5 1922 (Address) 5 E Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bonnie Brae — DATE OF BURIAL, Dec 7, 1922

20-UNDERTAKER, Burkler & Burkler — ADDRESS 1734 Eager

Spec.—1-10-21 M&T 1500 Blks.

D69779

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69779

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 Vine ST. 70 WARD)

2-FULL NAME Rose Kuhnberger

(a) RESIDENCE NO. 1933 Vine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, ~~or divorced~~ the ~~husband~~ (or) WIFE of Frang Kuhnberger

6 DATE OF BIRTH (month, day, and year) August 28 1857

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
65	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 639

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Riehmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Kate Avey

(Address): 1929 Vine St

15 DEC 5 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): DEC 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1922, to Dec 5th, 1922,

that I last saw h~~er~~ alive on Dec 4, 1922,

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Endo & Myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Nitration Oedema of Lungs

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph Gilchrist, M. D.

DEC 5 1922 19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Western — DATE OF BURIAL: DEC 8 1922

20 UNDERTAKER: Geo N Little — ADDRESS: 2700 EDMONDSON AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 5 1922

Spec.—1-10-21—M&T—1500 Bks.

D69780

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D69780

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 Baker ST., 15 WARD)

2-FULL NAME Alonzo Underwood

(a) RESIDENCE No. 1528 Baker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 7 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE DATA REQUIRED UNDER EACH HEADING should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ann Underwood

6 DATE OF BIRTH (month, day, and year) 4, 17 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman People's Court

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Underwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Switzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Ann Underwood (Address) 1528 Baker St.

15 Filed 12-5 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-4-1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 29, 1922, to Dec 4, 1922

that I last saw h[illegible] alive on Dec 3, 1922

and that death occurred, on the date stated above, at 3-10 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. N. Duvall, M. D.

12-6 1922 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: 12/6 1922

20 UNDERTAKER: Wm. M. Gawthrop ADDRESS: 2839 Rayner

Spec. 1 10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69781

CERTIFICATE OF DEATH.

31 D69781

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 421 E. Fort Ave. ST., 24 WARD)

2-FULL NAME Thomas J. Smith

(a) RESIDENCE NO. 421 E. Fort Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda C. Smith

6 DATE OF BIRTH (month, day, and year) Nov. 24 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Ann Page

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs. Ralph C. Percy
(Address) 421 E. Fort Ave.

15 Filed ....., 19 ..... Robert P. Harriss, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5th 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1921, to Dec 5, 1922, that I last saw h[illegible] alive on Dec 4th, 1922, and that death occurred, on the date stated above, at 2.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jno B Kolb, M. D.

Dr. (Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 12/7 1922

20 UNDERTAKER L. Few McCully

ADDRESS 1306 Fort Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 5-1922

Spec.—1-10-21—M&T—1500 Bks.

D69782

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69782

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH S.W. cor. Maplewood & Hickory St. Ward 27

REGISTERED NO.

CITY OF BALTIMORE: (No. Maplewood & Hickory St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lee Ehrlinger

(a) RESIDENCE NO. S.W. cor. Maplewood & Hickory St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) Wife of~~ Margaret Ehrlinger

6 DATE OF BIRTH (month, day, and year) 7/16/1893

7 AGE: Years 29; Months ~~5~~ 4; Days 18; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Conductor

(b) General nature of industry, business, or establishment in which employed (or employer): 078

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER John Ehrlinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant Mrs. Ehrlinger

(Address) Maplewood & Hickory St

15 Dec 5, 1922, 19 ...

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 3 1922

17

I HEREBY CERTIFY, That I attended deceased from about 2 years, 19 and, to Dec 3, 1922,

that I last saw h alive on Dec 1, 1922

and that death occurred, on the date stated above, at PM m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

about 2 years (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? don't kn

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray & C

(Signed) W. S. Riley, M. D.

, 19 (Address) 1632 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Dec 7, 19 22

20 UNDERTAKER: S. W. Gaston

ADDRESS: 1633 E Balto

DEC 5 1922

C. B.—WRITE PLAINLY, WITH UNFADING INK. THIS BLANK MUST BE FILLED OUT EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69783

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69783

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5 W. York St. St., 22 74-001 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattie Booker.(C)

12

(Residence in Baltimore: No. 5 W. York St. St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: Colored.

5-Single, Married, Widowed or Divorced, (Write the word.): Married.

6-DATE OF BIRTH: May 15th. 1896 (Month) (Day) (Year)

7-AGE: 26 yrs. 6 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Washington D.C.

PARENTS:

10-NAME OF FATHER: Minor Washington(C)

11-BIRTHPLACE OF FATHER, (State or Country): Queen Anne Co. Md.

12-MAIDEN NAME OF MOTHER: Louise Ashton(C)

13-BIRTHPLACE OF MOTHER, (State or Country): Petersburg Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Booker(C)husband.

(Address) 5 W. York St.

15-

Filed Dec 5 1922 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 2nd. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Richards M. D. (Coroner.)

Dec. 4th 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Dr. Sutherlen — DATE OF BURIAL: Dec 6 1922

20-UNDERTAKER: Brown & Tisdale — ADDRESS 1140

C 5 B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Physicians state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69784

159-002 D69784

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 S Dallas ST., 3 WARD)

2-FULL NAME Edwin. Musciewujewski

(a) RESIDENCE NO. 613 S Dallas ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 16 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Anthony Musciewujewski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Constence Krystkiewicz

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Constence Musciewujewski
(Address) 613 S Dallas

15 Dec 5 1922 Robert P. Harris, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1922, to Dec 4, 1922, that I last saw him alive on Dec. 4, 1922, and that death occurred, on the date stated above, at 430 p m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Trouble

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William D Kyser M. D.

1922 (Address) 601 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 6 1922
20 UNDERTAKER	ADDRESS
John Mastchler	1803 Bank 14

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 5 - 1922

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69785 90 D69785

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3032 Guilford Ave. ST. 12 WARD)

2-FULL NAME Gustus E. Messer

(a) RESIDENCE NO. 3032 Guilford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lavinia V. Messer

6 DATE OF BIRTH (month, day, and year) Jan. 30" 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: David Lorenz Messer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Erfurst East Prussia

12 MAIDEN NAME OF MOTHER: Marguretta Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bavaria

14 Informant: Philip L. Messer

(Address): 1846 W. Fayette St.

15 Filed 1922 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4" 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9 . 1922 . to Dec. 4 . 1922 . that I last saw him alive on Dec. 3 . 1922 . and that death occurred, on the date stated above, at 3.25 A m.

The CAUSE OF DEATH* was as follows:

Organic disease of heart, Valvular.

(duration) 2 yrs. 8 mos. 4 ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Howes Hoffman M. D.

12/4 19 22 (Address) 1809 Bolton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Dec 6" 1922

20 UNDERTAKER: Jos. L. B. Cook

ADDRESS: 1003 W. Balto St.

D69786

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-008 D69786

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph's Hospital St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Hearne Forbes, Jr.

(Residence in Baltimore: No. 2211 W. Lanvale St. St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Singl

6-DATE OF BIRTH. October 26, 1914
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
8 yrs. 1 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at school
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Theodore H. Forbes

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth B. Shew

13-BIRTHPLACE OF MOTHER (State or Country), Illinois

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theodore H. Forbes

(Address) Fallston, Md.

15- Filed DEC 8 1922, 191.... KUBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Fracture Base-Upon Chest.

Cause Runner by horses drawn wagon at Fallston, Md. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental (Duration) yrs., mos. ds.

(Signed) J. D. Hatter M. D.
(Coroner.)
Dec 5 1922 (Address) 506 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Dec 6, 1922
20-UNDERTAKER	ADDRESS
H. W. Jenkins Son's Co	McCulloh & Eutaw

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69787 D69787

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 Rabory ST., 18 WARD)

2-FULL NAME Ella D. Moore

(a) RESIDENCE NO. 725 Rabory ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-23-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Luther Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mildred Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mildred Moore
(Address) 725 Rabory St

15 Filed DEC 6 - 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 3, 1922, that I last saw her alive on Dec 2, 1922 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J Harry Glassman, M. D.

Dec 5 1922 (Address) 2687 Mosher Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Dec 6 1922

20 UNDERTAKER John N Joadrin — ADDRESS 1412 Mitchell St

N. B.—WRITE PLAINLY, WITH PENCIL OR PEN AND INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69788

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D69788

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 Ashland Ave ST. WARD)

2-FULL NAME Milton A. Greenwood

(a) RESIDENCE No. 1806 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Arthur Greenwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A. Naumann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Arthur Greenwood (Address) 1806 Ashland Ave

15 DEC 6-1922 ROBERT R. KNAUER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922 to Dec 3, 1922 that I last saw him alive on Dec 3, 1922 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows: Ulcerated Colitis following Pneumonia Lobar Hemorrhage Bowel

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) F. Reid Armiger M. D.

19 12-7 1922 (Address) 800 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL 12/5 1922

20 UNDERTAKER Philip Henry ADDRESS 2016 Adams

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Christina H. Kirkness

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69789

CERTIFICATE OF DEATH.

90 D69789

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 401 Edmondson Av. ST.; 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Christina H. Kirkness

(Residence in Baltimore: No. 401 Edmondson Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb. 28, 1885, 1
(Month) (Day) (Year)

7-AGE, 37 yrs. 9 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, William Koll.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Sophia Edutabou[illegible]

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward T. Kirkness.

(Address) 401 Edmondson Ave.

15 Filed DEC 6 - 1922 19[illegible] ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis
Dy Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Dec 5, 1922 (Address) 3[illegible] Rutland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Dec 7, 1922

20-UNDERTAKER A. Heuisler ADDRESS 32 S Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Louis M Deal)

D69790

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69790

CERTIFICATE OF DEATH.

1919

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Greenmount Ave Hosp St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura M. Deal

(Residence in Baltimore: No. 1711 Greenmount Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 28, 1885 (Month) (Day) (Year)

7-AGE, 37 yrs. 9 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Produce 045
(b) General nature of industry, business, or establishment in which employed (or employer)..... Merchant

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, J. W. Deal

11-BIRTHPLACE OF FATHER (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Nora J. Burke

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nora J. Deal

(Address) 2138 Baylor ave

15- DEC 6 - 1922 ROBERT R. KRAUTER,

Filed....., 191.... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 2, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows: Concussion of brain (Homicide)

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) F. J. Thomasgay M. D. (Coroner.)

Dec 6, 1922 (Address) 3632 Roland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Dec 6, 1922
20-UNDERTAKER	ADDRESS
Zurhorst & Zurhorst	739 Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D69791

160022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69791

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Garnett.

(a) RESIDENCE No. 216 23rd St. City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Robert Hackley (son in law)

6 DATE OF BIRTH (month, day, and year) Aug. 11, 1863

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59	3	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hone Labr

(b) General nature of industry, business, or establishment in which employed (or employer): Labr 640

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country): " Virginia

PARENTS

10 NAME OF FATHER Robert Garnett

11 BIRTHPLACE OF FATHER (city or town) (State or country): " Virginia

12 MAIDEN NAME OF MOTHER Julia Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " Virginia

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed DEC 6 - 1922, 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1922 to Dec 1, 1922, that I last saw him alive on Dec 1, 1922, and that death occurred, on the date stated above, at 10 35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pancreas

(duration) 1? yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 12/2/22

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Cecil H Bagley, M. D.

, 19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Dec 8 1922

20 UNDERTAKER: Wm Robert A Elliott — ADDRESS 1725 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

D69792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 D69792

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2514 Hudson ST., 1 WARD)

2-FULL NAME Gordon F. Smith

(a) RESIDENCE No. 2514 Hudson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3-1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At school.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frederick Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sophia Ratajzick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Frederick C. Smith
(Address) 2514 Hudson St.

15 Filed ..... 19..... ROBERT A. KRAUTER, Registrar

DEC 6 - 1922 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1922, to Dec 1, 1922,

that I last saw h[illegible] alive on Dec 1, 1922

and that death occurred, on the date stated above, at 2 15 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis.

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) A. Kate Insley, M. D.

, 19 (Address) 2558 S. Bell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: Dec 6 1922

20 UNDERTAKER: H. Sander & Sons — ADDRESS: 1718 Fleet St.

Spec.—1-10-21—M&T—1500 Bks.

D69793

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69793

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 S. Patterson Park Ave WARD 1)

2-FULL NAME Mary L. Cooper

(a) RESIDENCE NO. 114 S. Patterson Park Ave., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Cooper

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant Mrs Nelly Smullen
(Address) 1805 N Broadway

15 Filed DEC 6 1922 19 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1922, to Dec 4, 1922,
that I last saw her alive on Dec 4 1922,
and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Microscopic examination

(Signed) Caleb R Otter, M. D.

Dec 5. 1922 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Dec 6 1922
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69794

CERTIFICATE OF DEATH

113 D69794

1-PLACE OF DEATH Robt Garrett Hosp for Children — REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 27 N. Carey ST., 23 WARD)

2-FULL NAME John Edward Watts

(a) RESIDENCE NO. 1210 Marshall ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Aug 22 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Albert Wallameyer

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lillie Watts

13 BIRTHPLACE OF MOTHER (city or town) Brooklyn
(State or country) Maryland

14 Informant Lillie Watts
(Address) 1038 Patapsco St

15 Filed DEC 6-1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1922, to Dec 5, 1922, that I last saw him alive on Dec 5 1922, and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(duration) ..... yrs. ..... mos. 19 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. H. H. Cliff M. D.

12/5, 1922 (Address) 27 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery — DATE OF BURIAL Dec 7 1922

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69795

CERTIFICATE OF DEATH.

10 D69795

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp ST. WARD)

2-FULL NAME George Smith.

(a) RESIDENCE. No. 709 Light ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 5 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER William Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary Smith (Address) 709 Light St

15 Filed DEC 6 1922 19 [illegible] Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 1922, to Dec 6 1922, that I last saw him alive on Dec 6 1922, and that death occurred, on the date stated above, at 4:00 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal, tonsillar & pharyngeal

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Billy Lawson, M. D.

12/6/1922 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Dec 6 1922
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Uncleby.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69796

CERTIFICATE OF DEATH.

129 D69796

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 Woodbrook ST., (or) 15 (WARD) (Clowman)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelia V Uncleby

(a) RESIDENCE NO. 2408 Woodbrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marcus Uncleby

6 DATE OF BIRTH (month, day, and year) 4-28-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Vannon Slade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Elizabeth McLain

(Address) 2408 Woodbrook ave

15 Filed DEC 6-1922 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 5 1922

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1922, to Dec. 4th, 1922, that I last saw h-e alive on Dec 4, 1922, and that death occurred, on the date stated above, at 6.30a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Chronic Bright's Disease - Uremic Poisoning -

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None —

(Signed) C H Beelen M. D.

12-5, 1922 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Vernon Cem White Hall MD

DATE OF BURIAL Dec 7 1922

20 UNDERTAKER James J Ayres

ADDRESS 1324 Eutaw Pl

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69797 708 Ensor St 129 D69797

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Christs Institution Hospital ST., 11 WARD)

2-FULL NAME Carrie B. Williams

(a) RESIDENCE No. 328 W. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos N Wms

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 49; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co. Md

PARENTS

10 NAME OF FATHER: Wm Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co. Md

12 MAIDEN NAME OF MOTHER: Sarah Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Md

14 Informant: Thos N. Wms (Address) 328 W Hoffman St

15 Filed DEC 6 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 4, 1922

17

I HEREBY CERTIFY, That I attended deceased from November 15, 1922 to December 4, 1922.

that I last saw her alive on December 4, 1922.

and that death occurred, on the date stated above, at 12.40 P.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Bright Disease & complications of Diseases (duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Bright Disease & complication of Disease (duration) yrs. 4 mos. 19 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr G W Kennard, M. D.

12-4, 1922 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL 12-7 1922

20 UNDERTAKER: Denver Hensley — ADDRESS 1118 Bdle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69798

CERTIFICATE OF DEATH.

90 D69798

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henson

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed DEC 6 1922, 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 3 1922

17

I HEREBY CERTIFY, That I attended deceased from Feb. 10, 19 08, to December 3, 19 22, that I last saw him alive on December 3, 19 22, and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde W. Neill M. D.

12/4/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL 12/8/22

20 UNDERTAKER Samuel Hendley & Bro. ADDRESS 59

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69799

D69799

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 Carlton ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vina Davis

(a) RESIDENCE. No. 119 Carlton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Davis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Unknown

14 Informant Lucie Davis (Address) 503 Mount St.

15 Filed DEC 6 - 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-3— 1922

17

I HEREBY CERTIFY, That I attended deceased from from 12-1— 1922, to 12-3 1922,

that I last saw her alive on Dec. 3 1922,

and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Acute)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jas O Carper, M. D.

12/4, 1922 (Address) 1063 Wyoth ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12/6 1922
20 UNDERTAKER Samuel Hensley	ADDRESS 578 N Eddn

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69800

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69800

CERTIFICATE OF DEATH.

100-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 518 N. Bradford St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Sidney Sinft

(Residence in Baltimore: No. 518 N. Bradford St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	

6-DATE OF BIRTH, Oct 23 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 6 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Baby,
(b) General nature of Industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Sidney Sinft

11-BIRTHPLACE OF FATHER, (State or Country), Ohio

12-MAIDEN NAME OF MOTHER, Mary Jackson

13-BIRTHPLACE OF MOTHER, (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jackson Sinft

(Address) 518 N. Bradford

Filed DEC 6 - 1922

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 4, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. ....mos. 3 ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jos. H. Pattison M. D.
(Coroner.)

Dec 6 1922 (Address) 506 E. Northern

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery — DATE OF BURIAL, Dec 6, 1922

20-UNDERTAKER, Edward Bryan & Sons — ADDRESS 1631

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69801

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69801

114

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital. ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard W. Galvecht

(a) RESIDENCE. No. 835 So. Paca St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Galvecht.

6 DATE OF BIRTH (month, day, and year) July 5 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meter Repairer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gas. & Elec. Co.

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Geo. W. Galvecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Nellie E. Naylor.

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Nelson S. Galvecht

(Address) 835 So. Paca St. RELATIVE

15 Filed DEC 6 - 1922 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4, 19 22.

17

I HEREBY CERTIFY, That I attended deceased from 12/1/, 19 22, to 12/5, 19 22,

that I last saw h[illegible] alive on Dec. 5, 19 22,

and that death occurred, on the date stated above, at 11.20 a. m.

The CAUSE OF DEATH* was as follows:

General peritonitis.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Perforated duodenal ulcer (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 12/1/22.

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) J. Willis Crenshaw, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery Hamilton	Dec. 8 19 22
20 UNDERTAKER	ADDRESS
James DiGnan & Son	1000 S. Paca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69802

CERTIFICATE OF DEATH.

161-001

D69802

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Homewood Hospital

CITY OF BALTIMORE: (No. 2714 N. Charles ST., 18 WARD)

2-FULL NAME Baby Atkins

(a) RESIDENCE NO. 1022 Franklin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec-4-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Baby

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Atkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Mary Atkins
(Address) 1022 Franklin St.

15 Dec 6 1922 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 — 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 4 1922 to Dec 4 1922

that I last saw h alive on Dec 4 1922

and that death occurred, on the date stated above, at 7 A.C. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Degeneration of Placenta (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Observation

(Signed) Ira S. Tetterton, M. D.

12-6 1922 (Address) 2724 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL Dec 6 1922

20 UNDERTAKER .....

ADDRESS .....

Commissioner of Health.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

12/6 1922

D69803

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69803

CERTIFICATE OF DEATH.

181-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1531 Cole St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Louis Meier

(Residence in Baltimore: No. 1531 Cole St.; yrs., mos. ds.)

Be sure CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	Married

6-DATE OF BIRTH. unknown ..... 1.....
(Month) (Day) (Year)

7-AGE. about 48 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... unknown
(b) General nature of industry, business, or establishment in which employed (or employer)..... ?

9-BIRTHPLACE, (State or Country). Germany?

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country) unknown

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Dec 6 1922 Robert P. Garrison, 192.....
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, found dead on Nov 29 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

former pan Burning Illuminating Gas while Intoxicated accident

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) James M. Fenlon M. D.
(Coroner.)

Dec 4 1922 (Address) 706 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
PUBLIC CEMETERY.	Dec 6 1922

20-UNDERTAKER.	ADDRESS

Commissioner of Health.

THE MORGUE

D69804 HEALTH DEPARTMENT—CITY OF BALTIMORE D69804

CERTIFICATE OF DEATH.

1-PLACE OF DEATH S/S Dominion Miller en route to Registered No. C.....

City of BALTIMORE: (No. Baltimore off Cape Henry. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon Stapley. En route.

(Residence in Baltimore: No. England. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. Do not know. 1.....
(Month) (Day) (Year)

7-AGE. 18. --- --- yrs. mos. ds.

If LESS than 1 day, ... hrs. or .... min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mess boy S/S
(b) General nature of industry, business, or establishment in which employed (or employer): Dominion Miller.

9-BIRTHPLACE, (State or Country). England.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER. (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. S. Reavley. (Chief Captain).

(Address) S/S Dominion Miller. Pier 6 Locust Point.

15-

Filed DEC 8 1922 Robert P. Harrison, Registrar.

Burial permit issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 3rd, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart.
Oedema of the Lungs.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Dec. 8th, 1922 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Trinity Cemetery	Dec 7, 1922

20-UNDERTAKER. Robt F Turner ADDRESS 1442 N Broadway

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69805

D69805

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Peters

(a) RESIDENCE NO. 1510 E. Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Meta Masters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Henry Michel

(Address) 1510 E Oliver

15 [illegible] 6 1922 19 Robert P. Harris, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5, 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1922, to Dec. 5, 1922,

that I last saw him alive on Dec. 5, 1922,

and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Kruger, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dale Cemetery

DATE OF BURIAL Dec 9 1922

20 UNDERTAKER Robt J Inman

ADDRESS [illegible]

Burial Permit Office

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69806

CERTIFICATE OF DEATH.

Registered No. C. 179

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp. St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Trantanni

(Residence in Baltimore: No. 1006 Styles St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. July (Month) 10 (Day) 1920 (Year)

7-AGE. 2 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Dominick Trantanni

11-BIRTHPLACE OF FATHER. (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Domenick Trantanni

(Address) 1006 Styles St

15. Filed ..... 192.... Robert P. Garrison, Registrar.

C 6 - 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 4 (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Autopsy find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

3rd degree burns over chest abdomen & groins. Face & eyes. Result of Shock from accidentally spilling on herself (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Autopsy & Hospital (Duration) yrs. mos. ds.

(Signed) J. S. Falter M. D. (Coroner.)

12-6 192.2 (Address) 508 E. Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Dec 7 1922

20-UNDERTAKER.	ADDRESS
Wendell & Lippel Bros	370 Aisquith

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69807

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D69807

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4711 Ferndale Ave. WARD 38)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Callowhill

(a) RESIDENCE. NO. 4711 Ferndale Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alan S. Callowhill

6 DATE OF BIRTH (month, day, and year) June 9-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ashland Va

PARENTS

10 NAME OF FATHER Samuel Faust

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ludwig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Alan S. Callowhill

(Address) 4711 Ferndale Ave

15 Filed 1922 Robert P. Carrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19 1922, to Dec 4 1922, that I last saw h[illegible] alive on Dec 4th 1922, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Aortic Stenosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Daniel Miller, M. D.

, 19 (Address) 1506 N Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Dec 7 1922
20 UNDERTAKER	ADDRESS
Wm. J. Tickner & Sons	N & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

6-1922

Spec.—1-10-21—M&T—1500 Bks.

Powlett 422 Roland Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69808 D69808

CERTIFICATE OF DEATH.

73

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 7 Brachdale Rd. ST. 27th WARD)

2-FULL NAME Catherine E. Sinnwell

(a) RESIDENCE NO. 7 Brachdale Rd ST. 27th WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chas. H. Sinnwell

6 DATE OF BIRTH (month, day, and year) Nov 23 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	8	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home
(b) General nature of Industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Cunningham

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Morgan

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Mary E. Sinnwell
(Address) 7 Brachdale Rd.

15 Robert P. Harrison, Registrar
Burial Permit Clerk

C 6-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1922

17 I HEREBY CERTIFY, That I attended deceased from April 15 1922 to Dec. 6 1922,
that I last saw h alive on Dec-5 1922,
and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Exhaustion due to lack of food

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Parkinson's Disease

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) M. Tilton Porter, M. D.
12/6 1922 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Dec 7 1922

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fort Ave

Burial should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D69809

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69809

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 111 E Getting ST.; 24 WARD)

2-FULL NAME Lillian M Higgins

(a) RESIDENCE. NO. 111 E Getting ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 5 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nothing

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Kaufman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs M Higgins
(Address) 111 Gettysburg

15 Filed DEC 7 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1 1922, to Dec 5, 1922, that I last saw h alive on Dec 5, 1922, and that death occurred, on the date stated above, at 5:50 P m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Bottom

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Microscopic Exam

(Signed) [illegible], M. D.

Dec 8, 1922 (Address) 1715 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 8 1922

20 UNDERTAKER: Josiah Lyser — ADDRESS: 1600 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69810

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002 D69810

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Dukeland ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Ervin Lewis

(a) RESIDENCE. NO. 1810 Dukeland ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5th ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city.

PARENTS

10 NAME OF FATHER Earl Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Madonia Divers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Francis E Lewis
(Address) 1810 Dukeland ave

15 Filed DEC 7 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1922

17 I HEREBY CERTIFY, That I attended deceased from 11-10, 1922, to 12-6, 1922

that I last saw her alive on Dec 6, 1922

and that death occurred, on the date stated above, at 11.20 A.M.

The CAUSE OF DEATH* was as follows:

Asphyxia
Pallida.

(duration) yrs. - mos. 26 ds.

CONTRIBUTORY (Secondary) Congenital Weak Heart

(duration) yrs. mos. 26 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Cullen, M. D.

12/7/22 (Address) 2757 W. Mount ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 7 1922
20 UNDERTAKER	ADDRESS
Josiah Syfer	1600 W North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Rigby

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69811

CERTIFICATE OF DEATH.

101-001 D69811

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 20 WARD)

2-FULL NAME Phillip Rigby

(a) RESIDENCE NO. 4107 Mass. Ave, ST., Sumpter WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) APRIL 15 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72 y.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mrs Stella Hamley
(Address) 4107 Mass. Ave

15 Filed DEC 7 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1922, to Dec 5, 1922, that I last saw h alive on Dec. 5, 1922, and that death occurred, on the date stated above, at 2 30 A. m.

The CAUSE OF DEATH was as follows:

Double Lobar Pneumonia

1 hour (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure pulmonary Oedema. (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical note

(Signed) W C Caldwell, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: BALTIMORE GEM — DATE OF BURIAL 12/7 1922

20 UNDERTAKER: ROBERT T. BROOKS JSON — ADDRESS COR CALHOUN HOLLINS ST

BEFORE filling in Certificate, read carefully Instructions printed on page 3 hereof. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69812 D69812

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 629 W. 14th St., Hoffman WARD)

2-FULL NAME Amelia Biddle

(a) RESIDENCE NO. 529 W. 14th ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Biddle

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 070

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jennie Jones
(Address) 529 N. Hoffman

15 DEC 7-1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1922, to Dec 4, 1922, that I last saw h[illegible] alive on Dec 3, 1922, and that death occurred, on the date stated above, at 6.30, m.

The CAUSE OF DEATH* was as follows: Paralysis Cerebral Hemorrhage

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Horsley M. D.

Dec 6, 1922 Address) 712 S. Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Dec 7 1922

20 UNDERTAKER Sam'l. W. Chase & Son — ADDRESS 1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69813

CERTIFICATE OF DEATH.

100-001 D69813

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1630 - W - Mulberry ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Record) Milton Rogers

(a) RESIDENCE NO. 1630 - W - mulb'y ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9-1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs or ... min.
	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John W. Rogers

11 BIRTHPLACE OF FATHER (city or town) ~~Baltimore~~ (State or country) Md

12 MAIDEN NAME OF MOTHER Alma L Coats

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Md

14 Informant John W. Rogers (Address) 1630 W. Mulberry

15 Filed DEC 7 - 1922 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5 19 22

17 I HEREBY CERTIFY, That I attended deceased from 12-3, 1922, to 12-5, 1922, that I last saw him alive on 12-5, 1922, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

Coma

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Walter E Carey M. D.

, 19 (Address) 1630 W Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Dec. 7 1922
20 UNDERTAKER, Jas. H. Dennis	ADDRESS 1303 Freemason St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69814

CERTIFICATE OF DEATH.

57 ✓ D69814

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2303 Druid Place ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Seigel

(a) RESIDENCE NO. 109 N. Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Seigel

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 057

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1403 Eastlast

15 DEC 7 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/6 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1922, to Dec. 6, 1922, that I last saw h a alive on Dec 5, 1922, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Uraemia - sclerosis - diabetes

~~Cerebral hemorrh~~ chronic nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Frederick Lentz, M. D.

12-7, 1922 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehren Friendship Cem DATE OF BURIAL 12/9 1922

20 UNDERTAKER Jack Lewis ADDRESS 1403 Eastlast

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69815

CERTIFICATE OF DEATH.

101-001 D69815

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 St. Appleton St ST., 15 WARD)

2-FULL NAME Abraham Harlock

(a) RESIDENCE NO. 1527 St Appleton St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Etta Harlock

6 DATE OF BIRTH (month, day, and year) 1830

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rag assorter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Lewis 1839 E Balt St

15 DEC 7 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th 1922, to Dec 6 1922, that I last saw h[illegible] alive on Dec 6 1922, and that death occurred, on the date stated above, at 4 30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Senile

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Valvular Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical findings

(Signed) M Goldwater M. D.

, 19 (Address) 2338 Madeira

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fisher Rockdale	Dec 7 1922

20 UNDERTAKER Jack Lewis, ADDRESS 1839 E Balt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr. Long

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69816 — CERTIFICATE OF DEATH. — 31 — D69816

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 529 S. Luzerne Ave ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie E. Maxwell

(a) RESIDENCE No. 529 S. Luzerne Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph O. Maxwell

6 DATE OF BIRTH (month, day, and year) Feb. 21, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Hardecker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Bauernschmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Joseph O. Maxwell (Address) 529 S. Luzerne Ave

15 FILED DEC 7 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1922 to Dec 3, 1922, that I last saw h alive on Dec 3, 1922, and that death occurred, on the date stated above, at 9.32 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Long, M. D.

Dec 6 1922 (Address) 1701 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Dec. 9, 1922
20 UNDERTAKER	ADDRESS
J. Sander Sons	1710 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69817

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr Kram

47

D69817

CERTIFICATE OF DEATH.

6

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 N. Milton Ave ST., ... WARD)

2-FULL NAME Mary F. Nelson

(a) RESIDENCE NO. 127 N. Milton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Nelson

6 DATE OF BIRTH (month, day, and year) Dec. 12. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Franz Treibell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Reil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John Nelson 127 N. Milton Ave

15 Filed DEC 7 — 1922 ROBERT F. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 4 1922

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1921, to Dec 4, 1922, that I last saw her alive on Dec 4 1922 and that death occurred, on the date stated above, at 6.50 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast & liver

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 3/10/14

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Keene M.D.

12/6, 1922 (Address) 2600 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Dec 7, 1922
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. If UNDER 1 day, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Hillery

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69818

CERTIFICATE OF DEATH.

100-001 D69818

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1012 Stricker ST., 16 WARD)

2-FULL NAME Alice Beatrice Hillery

(a) RESIDENCE NO. 1012 Stricker st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 18, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Lloyd Hellery

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mildred Clark

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Walter Hillery
(Address) 1012 Stricker St.

15 Filed DEC 7 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1922, to Dec 5, 1922,

that I last saw her alive on Dec 5, 1922,

and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Frank Saunders, M. D.

, 19 (Address) 1122 Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	Dec 7th 1922
20 UNDERTAKER	ADDRESS
A. Jones	1120 Gilmor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69819

CERTIFICATE OF DEATH.

74-001 D69819

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 E. White Ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wagner

(a) RESIDENCE NO. 18 E. White Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Wagner

6 DATE OF BIRTH (month, day, and year): Aug 23rd 1849

7 AGE: Years 73 Months 3 Days 14

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clothing Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Conrad Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Theresa —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Wm. Wagner

(Address) 18 E. White Ave

15 Filed DEC 7 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 5th 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/3/ 1922, to 12/5 1922, that I last saw him alive on 12/5 1922, and that death occurred, on the date stated above, at 1 45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Grover Stone, M. D.

12/6 1922 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: Dec. 7th 1922

20 UNDERTAKER: Philip Young

ADDRESS: 2016 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69820

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D69820

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #10 E Gittings ST., 23 WARD)

2-FULL NAME Henry Frank

(a) RESIDENCE NO. #10 E Gitting ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a ~~If married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Stella Frank

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Mrs Elizabeth Johnson

(Address) 10 E Gittings St

15 Filed DEC 7 - 1922 ROBT. P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 — 6 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 6, 19 22, to Dec 6, 19 22,

that I last saw him alive on Dec 6, 19 22,

and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Fat

(Signed) Wm E Cuyler, M. D.

12/7, 1922 (Address) 1319 Eighth

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill. DATE OF BURIAL 12-8 1922

20 UNDERTAKER E & B Hasle ADDRESS 115 E West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69821

CERTIFICATE OF DEATH.

113 D69821

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 130 E Oxford ST.: 24 WARD)

2-FULL NAME Joseph Schilling IV

(a) RESIDENCE. NO. 130 E Oxford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 16 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jos Schilling Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Barbara Redmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Adolph Schilling Jr (Address) 130 E Oxford St

15 DEC 7 - 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 19 22, to Dec 6, 19 22, that I last saw h[illegible] alive on Dec 5, 19 22, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D

12/6, 19 22 (Address) 1221 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A A Co	12-7 1922
20 UNDERTAKER	ADDRESS
E & J. O'Hare	115 E 9th St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69822

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69822

188-003

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leary Brown

(Residence in Baltimore: No. 1219 Park Ave St.; yrs. 4 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: November 6, 1918 (Month) (Day) (Year)

7-AGE: 4 yrs. mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: student
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Mack Brown

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Mary Waddy

13-BIRTHPLACE OF MOTHER, (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mack Brown

(Address) 1219 Park Ave

15-

Filed DEC 7 - 1922 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 4, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to. his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) automobile accident

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Dec. 6, 1922 (Address) 2 E Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Laurel Cem. DATE OF BURIAL, 12/7 1922

20-UNDERTAKER, Samuel Hendley ADDRESS 578 Mobile

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69823

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Russell Tapscott

(Residence in Baltimore: No. 919 Hollins St St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	[illegible]

6-DATE OF BIRTH. June (Month) 28 (Day) 1922 (Year)

7-AGE. .....yrs. 5 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Wilson Tapscott

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. Elizabeth Brown

13-BIRTHPLACE OF MOTHER, (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hosp

(Address) Acosta

15-

Filed DEC 7 - 1922 ROBERT R. KRAUTER, Burial Permit Registrar. Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 5 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Autopsy find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

Due

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

12-6 1922 (Address) [illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Laurel Cemetary	Nov 7 1922
20-UNDERTAKER.	ADDRESS
Geo. W. H. Rochester	1443 Pennsylvania Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-002

D69824

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2622 Florence St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Diggs.

(Residence in Baltimore: No. 2622 Florence Rd. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, C.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec (Month) 4th (Day); 1922 (Year)

7-AGE, ...yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer)..... Son

9-BIRTHPLACE, (State or Country) Balto Md City.

PARENTS.

10-NAME OF FATHER, John C. Diggs

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Marion Spragg

13-BIRTHPLACE OF MOTHER (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John C. Diggs

(Address) 2622 Florence St

15-

Filed DEC 7 1922, 191.. ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 4th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Strangulation from Cord around Neck

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) H. Kolodzie M. D. (Coroner.)

Dec 7, 1922. (Address) 2622 Florence

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, MT Auburn

DATE OF BURIAL, Dec 7, 1922

20-UNDERTAKER David Easton

ADDRESS 916 Park

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69825

CERTIFICATE OF DEATH.

100-601 D69825

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1706 W. Mulberry St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Roberta A. Carter

(Residence in Baltimore: No. 1706 W. Mulberry St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH. Jan (Month) 17 (Day) 1921 (Year)

7-AGE. 1 yrs. 10 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER. Raymond Carter

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Roberta Palmer

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roberta Carter

(Address) 1706 W Mulberry St

15- DEC 7 - 1922 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 5 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) .....yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) .....yrs. ..... mos. 12 ds.

(Signed) James M Penland M. D. (Coroner.)

DEC 5 192 2 (Address) 700 E Chase

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL. Sharp St Meth | DATE OF BURIAL. Dec 7 192 2

20-UNDERTAKER. Daniel Easter | ADDRESS 916 Eden

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

1601 D69826

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 D69826

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Backert.

(a) RESIDENCE No. 610 S. Rose St. City ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~or WIFE of~~ (Parents) Andrew & Rose Backert

6 DATE OF BIRTH (month, day, and year) Jan. 23, 1918.

7 AGE: Years 4 Months 10 Days 13. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer) (")

(c) Name of employer (")

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Andrew Backert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Rose Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL. Records

15 Filed DEC 7 - 1922 ROBT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1922 to Dec. 6, 1922, that I last saw him alive on Dec. 6, 1922, and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(duration) About 1 month yrs. mos ds.

CONTRIBUTORY (Secondary) Post-Scarlatinal Nephritis - 9 days. Bronchopneumonia - 3-4 days. Acute Cardiac Dilatation - 2 days.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Meech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Dec. 7 1922

20 UNDERTAKER: Lilly & Zeller

ADDRESS 403 S. Wolfe St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69827

CERTIFICATE OF DEATH.

100-001 D69827

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 Lancaster St ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Cooper

(Residence in Baltimore: No. 1524 Lancaster St. St.; ..... yrs., 7 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April 26, 1922
(Month) (Day) (Year)

7-AGE, ... yrs. 7 mos. 9 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Ray A. Cooper.

11-BIRTHPLACE OF FATHER (State or Country), Virginia Ill.

12-MAIDEN NAME OF MOTHER Hannorah F. Kenney

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ray A. Cooper.

(Address) 1524 Lancaster St.

15-

Filed DEC 7 - 1922 (Sgd.) T. R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 5, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1922, to Dec 5 1922, that I saw him alive on December 5 1922, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

..... Bronchopneumonia. .....

....

....

..... (Duration) 0 yrs. 0 mos. 8 ds.

CONTRIBUTORY (Secondary) ..... None .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... Lawson Wilkins ..... M. D.

Dec. 5, 1922. (Address) 10 W. St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..8.. yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Holy Redeemer Cem.	Dec. 7, 1922
20-UNDERTAKER	ADDRESS
Lilly & Zeile	403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D69828

HEALTH DEPARTMENT—CITY OF BALTIMORE

51 D69828

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1811 E Fayette ST.: 6 WARD)

2-FULL NAME Earl Pope

(a) RESIDENCE. NO 1811 E Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 24/1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	8 mos	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Philip Pope

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Angelia Cuno Cuno

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Philip Pope

(Address) 1811 E Fayette St

15 Filed . 19 Robert H. KRAUTER, Registrar

DEC 7 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1922 to Dec 5, 1922

that I last saw him alive on 12 4, 1922

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Acute Bright's Kidney Disease

over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

12/6, 1922 (Signed) C. C. Regan M. D.

(Address) 2600 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	12/8 1922
20 UNDERTAKER J. J. Moran	ADDRESS 3000 E Balto

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

no other abnormal condition.
Acute Endocarditis &
Rheumatic Fever

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D69830 D69830

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

1-PLACE OF DEATH 1830

CITY OF BALTIMORE: (NO. ~~Bab~~ E Madison ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Christian Washington

(a) RESIDENCE. NO. 1830 E Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred dd yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 3 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Jerry Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Cora Christian

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Cora Washington
(Address) 1830 E Madison St

15 Filed ..... 19 .....

DEC 7 - 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1922, to Dec 5, 1922, that I last saw h.. alive on Dec 5, 1922, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Premature birth
Period of utero Gestation
about 6 months

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ✓

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Edward Fisher, M. D.

. 19 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 8 1922
20 UNDERTAKER	ADDRESS
Wm. R. C. Elliott	1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69829

D69829

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST.: WARD)

2-FULL NAME Mrs Bessie Schlachman

(a) RESIDENCE. NO. 2 Market Place. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? 16 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Israel Schlachman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 37 Years — Months — Days — If LESS than 1 day, hrs. — or — min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman Singer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Israel Schlachman (Address) 2 Market Place.

15 Filed DEC 7 - 1922 Neil A. Krauter Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/6 1922

I HEREBY CERTIFY, That I attended deceased from Dec 6 1922 to Dec 6 1922

that I last saw her alive on Dec 6 1922

and that death occurred, on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH was as follows:

Cerebral Embolism or Cerebral Thrombosis.

(duration) 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis, Uraemia, Hemiplegia (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Hebrew Hospital

Did an operation precede death? No Date of Dec 6 1922

Was there an autopsy? No

What test confirmed diagnosis? Only Clinical diagnosis

(Signed) Abe Greenberg, M. D.

12/6 1922 (Address) Hebrew Hosp Pa.

•State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hening Rem

20 UNDERTAKER Max Levinson

DATE OF BURIAL 12/7. 1922

ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3

D69831

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Penitentiary ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Williams alias

(a) RESIDENCE. NO. ..... ST. ..... WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) February-10-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Savannah Ga.

PARENTS

10 NAME OF FATHER W. W. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Savannah Ga.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Savannah Ga.

14 Informant (Address) Md. Penitentiary

15 DEC 7-1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November-30 1922

17

I HEREBY CERTIFY, That I attended deceased from July-25- 1922, to November 30, 1922, that I last saw him alive on November-30, 1922, and that death occurred, on the date stated above, at 4-55 p. m.

The CAUSE OF DEATH* was as follows:

Toxemia and Exhaustion

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 3 yrs. 4 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Examination

(Signed) William H. Edwards, M. D.

12/1, 1922 (Address) Maryland Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS DEC 7-1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69832

CERTIFICATE OF DEATH.

X 100-001 D69832

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Grace Fulton

(a) RESIDENCE NO. Mill Stone, Washington Co. St., WARD, Md.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mr. A. J. Fulton

6 DATE OF BIRTH (month, day, and year) Jan. 9, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	36	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Morgan County
(State or country) West Virginia

PARENTS

10 NAME OF FATHER William H. McCullough

11 BIRTHPLACE OF FATHER (city or town) Lancaster
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Elizabeth Rockwell

13 BIRTHPLACE OF MOTHER (city or town) Morgan Co.
(State or country) West Virginia

14 Informant A. J. Fulton
(Address) Hancock, Md.

15 Filed DEC 7-1922 ROBERT R. KRAUTER, Burial Permit Clerk.

Via Western Md. Railroad Escort - A. J. FULTON

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1922 to Dec. 6, 1922

that I last saw h alive on Dec 6, 1922

and that death occurred, on the date stated above, at 5.00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) /

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Captain Pendleton, M. D.

(Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Berkeley Springs, W. Va.

DATE OF BURIAL: 12/7 19 22

20 UNDERTAKER: Henry W. Sears & Son

ADDRESS: 805 W. Calvert

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69833 91-002 D69833

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Howard

(a) RESIDENCE. No. Mt Hope Retreat ST., 28 WARD. Bay View - Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? 60 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	not Known

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	60	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Long Shoreman

(b) General nature of industry, business, or establishment in which employed (or employer) Shipping 074

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not Known Ohio

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) " not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) Not Known

14 Informant Records of Mt Hope Retreat (Address) Mt. Hope Md.

15 Filed 7-1922, 19.... Robert F. Barrett Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 11th, 1921, to Dec 7th, 1922, that I last saw him alive on Dec 6th, 1922, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:—

Chronic Gastritis -
(with Cerebral Atherosma)

abt (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Sec - Dementia -
abt (duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Came from Bay View - Don't Know

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Dec 7, 1922 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Dec 9/ 1922

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69834 D69834

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 1854 K HR Female

REGISTERED NO. 4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 East Fourth St.; WARD)

2-FULL NAME Ellen E. Willson

(a) RESIDENCE. (No. "Warrington" Queenstown, Maryland WARD.)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Queenstown, Md.
(State or country)

PARENTS

10 NAME OF FATHER Dr Thomas Willson

11 BIRTHPLACE OF FATHER (city or town) Red Bank
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen E. Browne

13 BIRTHPLACE OF MOTHER (city or town) Queenstown
(State or country) Md.

14 Informant Mrs E. W. Creecy
(Address) Deep Town Md

15 Filed ....., 19.... Robert P. Harris, Registrar

C 7-1922 Burial Forest Glen

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 19, 1922 to Dec 7, 1922

that I last saw her alive on Dec 6, 1922,

and that death occurred, on the date stated above, at 5.20 p. m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Fracture of right femur (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? own

Did an operation precede death? None Date of

Was there an autopsy? none

What test confirmed diagnosis?

(Signed) H. A. Bowden, M. D.

12/7 1922 (Address) 1517 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Salem Town Md. DATE OF BURIAL: Dec 7 1922

UNDERTAKER: Henry Jenkins Son & Co ADDRESS: Eutaw & Fayette Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69835

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

44

D69835

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. Ridgley + Rusk Aves St.: 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME George M. Koerner

(Residence in Baltimore: No. Ridgley + Rusk Aves St.: 20 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: ? (Month) ..... (Day) ....., 1849 (Year)

7 AGE: 73 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Andrew Koerner

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Asked + not Known

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Harry Koerner
(Address): Ridgley + Rusk Ave

15 Robert F. Hartman,
Dist. ....., 191.....
Burial Permit Clerk. REGISTRAR

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

7 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. (Month) 6 (Day), 1922 (Year)

17. I HEREBY CERTIFY. That I attended deceased from Aug. 1922 to. Dec 6 1922
that I saw h imalive on Dec 5 1922
and that death occurred, on the date stated above, at 11 50 A.m.
The CAUSE OF DEATH* was as follows:

Infiltrating Carcinoma

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harold W. Wood M. D.
12/16/22 (Address) 2020 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Bath Cemetery — DATE OF BURIAL: Dec 8 .....191.....

20 UNDERTAKER: W S Marshall — ADDRESS: 3539 Falls Road

Spec.—1-10-21—M&T—1500 Blks.

(Ella V. Sharp) ✓

D69836

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69836

CERTIFICATE OF DEATH. X 118-002

1-PLACE OF DEATH Church Home Inf 6

CITY OF BALTIMORE: (No.) Broadway & Fairmount ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ella Sharp

(a) RESIDENCE NO. 53 James ST., WARD Bristol Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph L. Sharp

6 DATE OF BIRTH (month, day, and year) Jan. 7. 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Cedarville Va.
(State or country)

PARENTS

10 NAME OF FATHER Henry L. Kendrick

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret E. Price

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Joseph L. Sharp
(Address) Huntington W. Va.

15 Filed ....., 19..... Registrar

7-1927 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7, 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1927, to Dec 7, 1927, that I last saw her alive on Dec 7, 1927, and that death occurred, on the date stated above, at 12:30 p. m.

The CAUSE OF DEATH* was as follows:

Edema Lungs.

(duration) yrs. about mos 5 ds.

CONTRIBUTORY (Secondary) / (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Cayetano Pangilinan, M. D.

19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bristol Tenn

DATE OF BURIAL 12/9/27 19

20 UNDERTAKER H. E. Hughes

ADDRESS 1st & Broadway

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Intestinal Obstruction

Spec.—1-10-21—M&T—1500 Blks.

D69837

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69837

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 Forrest ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary R Rahm

(a) RESIDENCE NO. 805 Forrest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wh

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Rahm

6 DATE OF BIRTH (month, day, and year): Mch 9 - 1882

7 AGE: Years 40 Months 8 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington DC

PARENTS

10 NAME OF FATHER: John Lingerfelter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Rose Wilman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Louis Rahm (Address): 805 Forrest St

15 Filed 7-1922, 19 ROBERT P. LATTNER Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1922, to Dec 3, 1922, that I last saw h[er] alive on Dec 3, 1922, and that death occurred, on the date stated above, at 140 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus
adnexia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Washington D.C.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) A. A. Hornstein, M. D.

12/6, 1922 (Address) 733 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park. 12/8/ 1922 DATE OF BURIAL

20 UNDERTAKER: Wm. Coats, 50 E. Monument ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69838 X 89 ✓ D69838

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 E. 28th ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Little Burn.

(a) RESIDENCE NO. 1726 E. 28th ST., WARD South Carolina
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie Magdalene

6 DATE OF BIRTH (month, day, and year) Sept 19 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretarial work

(b) General nature of industry, business, or establishment in which employed (or employer) Store supplies

(c) Name of employer Armstrong Store Mfg. Co

9 BIRTHPLACE (city or town) Charleston S. C.
(State or country)

PARENTS

10 NAME OF FATHER Frank Burn

11 BIRTHPLACE OF FATHER (city or town) Charlestown S.C.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Julia Disher

13 BIRTHPLACE OF MOTHER (city or town) Charlestown S.C.
(State or country)

14 Informant Mrs. Elsie Magdalene Burn
(Address) 216 C St NE Washington D.C.

15 DEC 8 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1922, to Dec 7, 1922, that I last saw him alive on Dec 6, 1922, and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) Chas Wilbur Stewart M. D.

12/7, 1922 (Address) 1738 E. 28th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C

DATE OF BURIAL Dec 8 1922

20 UNDERTAKER J. E. Diedrich

ADDRESS 2008 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69839

CERTIFICATE OF DEATH.

129 D69839

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1815 Thomas Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Miller Bailey

(Residence in Baltimore: No. 1815 Thomas Ave St.; 6 yrs., + mos., + ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Aug. (Month) 14 (Day), 1847 (Year)

7-AGE. 75 yrs. 3 mos. 23 ds. If LESS than 1 day, ... hrs. or X min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): R.R. Carpenter

9-BIRTHPLACE. (State or Country). Pennsylvania

PARENTS.

10-NAME OF FATHER. Jacob Bailey

11-BIRTHPLACE OF FATHER (State or Country). Penna.

12-MAIDEN NAME OF MOTHER Miller

13-BIRTHPLACE OF MOTHER (State or Country). Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H.V. Bailey

(Address) 1205 East North ave

15- DEC 8-1922 ROBT. R. KRAUTER, Registrar.

Filed....., 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 7th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 1918, to Dec. 7th 1922, that I saw him alive on Dec. 1st 1922, and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH*, was as follows: Dilatation of heart, mitral lesions, Arterio-sclerosis, Albuminuria

(Duration) More than five years.

CONTRIBUTORY (Secondary) X (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Hoffman M. D.

12-7-, 1922 (Address) 3402 Walbrook Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. X mos. ..... ds. In the State ..... yrs. X mos. ..... ds.

Where was disease contracted, if not at place of death? X

Former or usual residence X

19-PLACE OF BURIAL, OR REMOVAL. Druid Ridge

DATE OF BURIAL. Dec 9, 1922

20-UNDERTAKER. W. S. Marshall

ADDRESS 3539 Fallsway

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69840

CERTIFICATE OF DEATH. 74-601

D69840

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Janet Duncan Reese

(a) RESIDENCE NO. 235 W. Lanvale St., Balto. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Reese

6 DATE OF BIRTH (month, day, and year) April 30. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	66	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house duties

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Minot Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret W. Babcock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Pa

14 Informant Minot Barrett (Address) 235 W. Lanvale St

15 FILED DEC 8 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 6 1922

17 I HEREBY CERTIFY, That I attended deceased from November 19, 1922, to December 6, 1922, that I last saw her alive on December 6, 1922, and that death occurred, on the date stated above, at 3:25 a.m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Pachymeningitis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov 24, 1922

Was there an autopsy? Cranial - only

What test confirmed diagnosis? Autopsy

(Signed) Norman E. Tannenbaum M.D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park (Dec 8 - 1922) DATE OF BURIAL

20 UNDERTAKER: John O. Mitchell ADDRESS 120 W. Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Wokoun.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69841 D69841

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 Montebello Ter ST., 27 WARD)

2-FULL NAME Mrs Wilhelmina Wokoun

(a) RESIDENCE NO. 127 Montebello Terrace ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Wokoun

6 DATE OF BIRTH (month, day, and year) Dec 10 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER John Zarpentin.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Reuscher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank. Wokoun (Husband)
(Address) 127 Montebello Terrace

15 DEC 8—1922 ROBERT P. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 30th, 1922, to Dec 7th, 1922, that I last saw h-er alive on Dec 7th, 1922, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at Home.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) L. L. Gordy, M. D.

12-7, 1922 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Dec 11 — 1922

20 UNDERTAKER Edw O. Mitchell — ADDRESS 1201 E. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D69842

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69842

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 10 N. Monroe ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Fachs Bennett

(Residence in Baltimore: No. 10 N. Monroe St.: 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widowed

6-DATE OF BIRTH: July (Month) 27 (Day), 1839 (Year)

7-AGE: 83 yrs. 4 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Louis Riddell

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Catherine Stoffel

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Augusta Gail

(Address) 10 N. Monroe st

15- Rec'd DEC 8 — 1922 191.. ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 7, (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1922, to Dec. 7, 1922, that I saw her alive on Dec. 7, 1922, and that death occurred, on the date stated above, at 12:10 p.m.

The CAUSE OF DEATH* was as follows:

Senile debility and Cardiac Weakness

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hardening of arteries

(Duration) 2 yrs. mos. ds.

(Signed) E. E. Corkey M. D.

Dec. 7, 1922 (Address) 14 N. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, Dec 9, 1922

20-UNDERTAKER Chas. S. Black

ADDRESS 742 W. Baltimore

Cause of death must be given in plain English. Do not use abbreviations or technical terms. Each statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Oxenham.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69843

CERTIFICATE OF DEATH.

162 D69843

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2229 E. Fayette St ST., 6 WARD)

2-FULL NAME Douglas M. Oxenham

(a) RESIDENCE NO. 2229 E. Fayette St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
			7.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Douglas M. Oxenham

11 BIRTHPLACE OF FATHER (city or town) Easton, Md
(State or country)

12 MAIDEN NAME OF MOTHER Lola Matheus

13 BIRTHPLACE OF MOTHER (city or town) Sommerset
(State or country) Somerset Co. Md.

14 Informant Douglas M. Oxenham
(Address) 2229 E. Fayette st

15 File DEC 8 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1922, to Dec. 7, 1922,
that I last saw h alive on Dec. 6, 1922,
and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Atelectasis.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none.

(Signed) Allen L. Oxenham, M. D.
12-7-, 1922 (Address) 3139 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Crisfield Md — DATE OF BURIAL 12/8 1922

20 UNDERTAKER Philip Herrig — ADDRESS 2016 Adams

HEALTH DEPARTMENT--CITY OF BALTIMORE

D69844

D69844

CERTIFICATE OF DEATH

X 100-001

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2938 St. Paul St. ST.: 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Austin Smith.

(Residence in Baltimore: No. home. St.; ..... yrs. ..... mos. 20 ds.)

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): married.

6 DATE OF BIRTH: March 18, 1871 (Month) (Day) (Year)

7 AGE: 51 yrs. ..... mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer): Dk 5

9 BIRTHPLACE (State or country): Richmond Va.

PARENTS

10 NAME OF FATHER: Austin Smith

11 BIRTHPLACE OF FATHER (State or country): Fredericksburg Va

12 MAIDEN NAME OF MOTHER: Betty Harrison

13 BIRTHPLACE OF MOTHER (State or country): Fredericksburg Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. McQueen

(Address) 17 Francis St. City

15 DEC 8-1922 ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. (Month) 7 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1922, to Dec. 7, 1922, that I saw him alive on Dec. 7, 1922, and that death occurred, on the date stated above, at 11:15 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, prob. bronchopneu

(Duration) ..... yrs. ..... mos. 3 ds

Contributory (SECONDARY) Secondary anemia 1 yr. Arteriosclerosis & arteriolar nephro pathy

(Duration) 20 yrs. ..... mos. ..... ds.

(Signed) Norman B. Cole M. D.

Dec. 8, 1922 (Address) 1035 N. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Former or usual residence: Richmond Va

19 PLACE OF BURIAL OR REMOVAL: Richmond Va

DATE OF BURIAL: Dec 12, 1922

20 UNDERTAKER: Robert Brookes and HOLLINS

ADDRESS CALHOU

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69845

CERTIFICATE OF DEATH.

99-002 D69845

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 Wilson St ST. 14 WARD)

2-FULL NAME Benjamin M. Johnson

(a) RESIDENCE NO. 533 Wilson St ST. 14 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
6				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. city
(State or country)

PARENTS

10 NAME OF FATHER Charles H. Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto.

12 MAIDEN NAME OF MOTHER Alice G. Brown

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co.
(State or country)

14 Informant Edith Brown
(Address) 533 Wilson St

15 DEC 8 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-5-1922

17 I HEREBY CERTIFY, That I attended deceased from 12-3-, 1922, to 12-5-, 1922

that I last saw him alive on " , 19

and that death occurred, on the date stated above, at 12 m. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. 1 mos 5 ds.

CONTRIBUTORY (Secondary) Marasmus, Chron. Bronchitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? "

What test confirmed diagnosis?

(Signed) J M Cardozo, M. D.

12-6-1922 (Address) 1524 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Dec 8 1922

20 UNDERTAKER John H Toadvine — ADDRESS 1424 Pine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1600 17. D69846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 84 D69846

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME Stephen Wright

(a) RESIDENCE NO. Shanton, Iowa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Leta R. Waught (Wife).

6 DATE OF BIRTH (month, day, and year) Jan 8, 1893.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	29	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10 NAME OF FATHER: Frank Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Iowa.

12 MAIDEN NAME OF MOTHER: May Randall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Iowa.

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records.

15 Filed DEC 8-1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1922, to Dec. 7, 1922, that I last saw him alive on Dec. 7, 1922, and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor. cerebellar and brain stem—glioma

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Yes Date of Dec 6

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) F. L. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shanton Ia — DATE OF BURIAL: 12/9/22

20 UNDERTAKER: A. E. Wyckoff & Son — ADDRESS: N York

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

(Vavra)

D69847

CERTIFICATE OF DEATH.

44

D69847

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 N. Modena ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Vavra

(Residence in Baltimore: No. 810 N. Modena St.; 46 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) J. 1 (Day) Brown, 1 (Year)

7-AGE, 75 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Jos. Brown

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Mrs. Brown

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Vavra

(Address) 810 N. Modena St

15-

Filed DEC 8-1922, 19.., ROBERT F. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 6 (Day), 1922 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Dec 1 1922, to Dec 6 1922, that I saw h[er] alive on Dec 6 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Colitis

4

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Wm. O. Krauter M. D.

Dec 7, 1922 (Address) 1906 Hartford Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Dec. 9, 1922

20-UNDERTAKER Hartford Funeral Home

ADDRESS 1906 Hartford Ave

important. See instructions on back of certificate.

D69848

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69848

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 821 E. Pratt St. 3 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Fannie Feinberg

(Residence in Baltimore: No. 821 E. Pratt st St.; 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

6-DATE OF BIRTH. Unknown 1.....
(Month) (Day) (Year)

7-AGE. 83 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Roumania

PARENTS.

10-NAME OF FATHER. Samuel Kauffman

11-BIRTHPLACE OF FATHER, (State or Country). Roumania

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Roumania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Feinberg

(Address) 821 E. Pratt St

15- Date DEC 8 - 1922

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 7½ 192 2
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said Inquest, aforesaid find that said deceased came to her death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Heart Failure
or cvel

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. B. Horton M. D.
(Coroner.)

Dec 8 192 2 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mount Lorraine DATE OF BURIAL. Dec 7- 1922

20-UNDERTAKER. Jacot Sons ADDRESS 1432 E Pratt St

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D69849 HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D69849

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1729 E. Fairmount St., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Witzenberg

(a) RESIDENCE NO. 1729 E. Fairmount ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 14 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Solomon Witzenberg

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Michel Bugatch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Louis 1439 Eutaw St

15 Filed DEC 8 1922 19.....

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/7 1922

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1921, to Dec 7th, 1922, that I last saw her alive on ....., 19....., and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the abdomen (duration) yrs. 19 mos ... ds.

CONTRIBUTORY (Secondary) Intestinal obstruction (duration) yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of about 14 mos ago

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) A F Reis, M. D.

Dec 8, 1922 (Address) 24 E Mt Vernon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrem Rosedale

DATE OF BURIAL 12/8 1922

20 UNDERTAKER Jack Louis

ADDRESS 1439 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso i

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Liver organ involved
Intestines

Spec.—1-10-21—M&T—1500 Bks.

D69850

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69850

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3109 E. Balto. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Meehan

(a) RESIDENCE NO. 3109 E. Balto. ST., 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Meehan

6 DATE OF BIRTH (month, day, and year) Jan 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	62	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer for,

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Dennis Meehan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Meehan

(Address) 3109 E. Baltimore

15 Filed DEC 8 1922, 19 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6th 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 8, 1922, to Dec 6, 1922

that I last saw him alive on Dec 5, 1922

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH was as follows:

Chronic Valvular Heart disease

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo. H. Eller, M. D.

Dec 8, 1922 (Address) 1937 Gough St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Dec 9 1922

20 UNDERTAKER John A. Noonan

ADDRESS 3000 E. Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69851

CERTIFICATE OF DEATH.

74-001

D69851

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 914 So. 3rd St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Rose P. Schierer

(Residence in Baltimore: No. 927 So. Elwood Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: May 20th 1876
(Month) (Day) (Year)

7-AGE: 46 yrs. 6 mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Inspector in
(b) General nature of industry, business, or establishment in which employed (or employer): tin Can factory

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Patrick McGinney

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Anna Costello

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Pschierer

(Address) 927 So. Elwood Ave

15. Filed DEC 8 - 1922 192.. ROBERT P. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 6th
(Month) (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. P. Hutton M. D.
(Coroner.)

Dec 6 192 2 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Baltimore

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds. Md

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Mary's Rooms,	Dec 9 1922

20-UNDERTAKER.	ADDRESS
John A Norman	3000 E Balto.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69852

CERTIFICATE OF DEATH.

124 D69852

REGISTERED NO.

1-PLACE OF DEATH Lemwood Hospital

CITY OF BALTIMORE: (No. 2124 N. Charles ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bertha Kraft

(a) RESIDENCE. No. 1522 Jackson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gustav Kraft.

6 DATE OF BIRTH (month, day, and year) Oct 29 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Massachusetts

PARENTS

10 NAME OF FATHER John Kaffenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant Sister Mrs. Bush (Address) 1414 Ramsdell

13 DEC 8-1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 6. 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1922, to 12.6.22, 19..;

that I last saw her alive on 12.6.22, 19..;

and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Surgical Shock.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Infected Gall Bladder

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1522 Jackson St.

Did an operation precede death? yes. Date of 12.6.22

Was there an autopsy? no

What test confirmed diagnosis? Operation.

(Signed) Philip R. Cowlin M. D.

12.6.22 19.. (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Dec. 9 1922

20 UNDERTAKER: Margaret D. Flynn — ADDRESS: 1422 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69853

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1822 001

D69853

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Jas Lee Drinks

(Residence in Baltimore: No. 59 mason st - St.; yrs. 4 mos. 3 ds. 13)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Sngle

6-DATE OF BIRTH. Aug. (Month) 23 (Day) 1918 (Year)

7-AGE. 4 yrs. 3 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None -
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto city

PARENTS.

10-NAME OF FATHER. Jas L. Drinks

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary McCormick

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Drinks

(Address) 59 Mason St

15- Filed DEC 8 - 1922 192 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 6 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock following Traumatic amputation of both Legs

(Duration) yrs. a few hours mos. ds.

CONTRIBUTORY (Secondary) Run over by R.R. Train

(Duration) yrs. mos. ds.

(Signed) W K Gorsuch M. D. (Coroner.)

12-8 1922 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Cross Cemetery A.A. DATE OF BURIAL. Dec. 9 1922

20-UNDERTAKER. Margaret G. Flynn ADDRESS 1422 Light St.

~~Property of Maryland State Department of Education~~ is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69854 38 D69854

CERTIFICATE OF DEATH.

D69854

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Garkeies

(a) RESIDENCE. NO. University Hospital ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Gerry Garkeies

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rica Johnson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mother JOHN
(Address)

15 DEC 8-1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1922, to Dec 5, 1922, that I last saw him alive on Dec. 5, 1922, and that death occurred, on the date stated above, at 8:25 P m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis
and
Prematurity

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann and Typical findings

(Signed) Norwood Wilson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL DATE OF BURIAL DEC 8 1922 19

20 UNDERTAKER ADDRESS

Commissioner Health.

Per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69855

CERTIFICATE OF DEATH.

91-002

D69855

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 E. Preston ST. 10 WARD)

2-FULL NAME Elizabeth Woodrow

(a) RESIDENCE. NO. 1205 E. Preston ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin J. Woodrow

6 DATE OF BIRTH (month, day, and year) 4/15/1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER John Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md

14 Informant John Woodrow (Address) 1205 E Preston St

15 Filed DEC 8 - 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1922, to Dec. 6, 1922, that I last saw her alive on Dec. 5, 1922, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) acute dilitation of heart (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross

(Signed) S. Leiknagness, M. D.

12/, 1922 (Address) 1205 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Dec 8 1922
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Hanford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69856

CERTIFICATE OF DEATH.

49 D69856

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE. (No. Municipal Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Adam Borneman

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	71	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Borneman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Municipal Hospital Records.

15 Filed DEC 8-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 3, 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1922, to December 3, 1922.

that I last saw him alive on December 3, 1922.

and that death occurred, on the date stated above, at 1:35 P.M.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of glands on left side of neck

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) C. Richardson Joyner, M. D.

12/4, 1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cemetery	Dec. 9 1922
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1795 Harford Ave

D69857 (Adelstern) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE D69857

CERTIFICATE OF DEATH.

129 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 N Paca ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Adelstern

(a) RESIDENCE NO. 410 N Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Sngl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) .015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Galicia Russ

PARENTS

10 NAME OF FATHER Jacob Adelstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Kerner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Welch.

(Address) 821 N. Carrollton Ave

15 Filed DEC 8 - 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1922, to Dec 6, 1922, that I last saw him alive on Dec 6, 1922, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 0 yrs. 9 mos 6 ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 410 N Paca St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R B Kenyon, M. D.

Dec 7, 1922 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 10 1922
20 UNDERTAKER	ADDRESS
Robt Schnauer	N. Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69858 (struck) 31 D69858

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hazelwood Ave. Cole'ge, ST., 76 WARD)

2-FULL NAME John C. V. Buettner

(a) RESIDENCE NO. Hazelwood near Cole Ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 3 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Louise R. Buettner

6 DATE OF BIRTH (month, day, and year) Sept. 12 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Straw Hatter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER August Buettner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Veronica Hirsch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Louise R. Buettner Hazelwood & Cole Ave

15 Filed DEC 8-1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8, 1922.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1922, to Dec. 8, 1922, that I last saw h. alive on Dec. 7th 1922 and that death occurred, on the date stated above, at 9½ A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (both upper lobes) (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Culbreth, M. D.

1428, 1922 (Address) Raspeburg, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Dec. 11 1922

20 UNDERTAKER Henry Hordt Son ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69859

CERTIFICATE OF DEATH.

74-001 D69859

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 Aisquith St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alverta Rinehart

(a) RESIDENCE NO. 817 Aisquith St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: HUSBAND of the late Geo. Rinehart

6 DATE OF BIRTH (month, day, and year): Dec. 22, 1839

7 AGE — Years: 82 — Months: 11 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Wm. Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Mrs. Laura Rinehart 817 Aisquith St.

15 Filed SEP 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 14, 1917, to Dec 5, 1922, that I last saw h[illegible] alive on Dec 6, 1922 and that death occurred, on the date stated above, at 12:15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) P. J. Hornickel, M. D.

12/6, 1922 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Dec. 11 1922

20 UNDERTAKER: Henry Hoxell Son — ADDRESS: 1211 E. Eager St.

IMPORTANT—Before answering, read carefully directions printed on back. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69860 D69860

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 E. Federal St. ST., 9 WARD)

2-FULL NAME Theresa Uhl

(a) RESIDENCE NO. 1401 E. Federal St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Henry Uhl

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	About 58	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Vincent Diegelmann

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Wilmelmina Mehrling

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mr. Henry Uhl

(Address) 1401 E. Federal St.

15 Filed 19 [illegible] R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec.-5-1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1922, to Dec 5, 1922, that I last saw her alive on Dec 5, 1922 and that death occurred, on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of 1921

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fritz S Kinzey, M. D.

19 (Address) 2700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery.

DATE OF BURIAL: De.-9-1922

20 UNDERTAKER: Henry Hoerdt Son

ADDRESS: 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69861 HEALTH DEPARTMENT—CITY OF BALTIMORE D69861

CERTIFICATE OF DEATH. 112

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 869 N. Howard ST., 11 WARD)

2-FULL NAME Elizabeth Knuttel

(a) RESIDENCE NO. 869 N. Howard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced
HUSBAND of Frederick Knuttel.
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John Gayford

11 BIRTHPLACE OF FATHER (city or town) England (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs. Frederick Knuttel
(Address) 869 N. Howard St.

15 Filed ....., 19 ROBERT R. KRAUTER, Registrar
DEC 6 - 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7 1922

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,

that I last saw h... alive on ....., 19...

and that death occurred, on the date stated above, at 4 45 W. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

Senility

.....(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ....., M. D.

....., 19... (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cathedral Holy Redeemer Cemetery	Dec. 9 1922
20 UNDERTAKER	ADDRESS
Henry Horck Son	1201 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 74-00 D69862

D69862

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Linwood Av ST. 27 WARD) Mt Washington

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerucian Kefel

(a) RESIDENCE (Usual place of abode) No. Linwood Ave ST., 27 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 28 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
over	70	12	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md.

PARENTS

10 NAME OF FATHER David H Haffaker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md.

12 MAIDEN NAME OF MOTHER Schuman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Geo W Troen (Address) Linwood Ave

15 Filed DEC 8 - 1922 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from October 8, 1922, to Dec 7, 1922, that I last saw h[illegible] alive on Dec 7, 1922, and that death occurred, on the date stated above, at 5.25 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Paralysis right side

(duration) yrs. 2 mos. 12 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Manchester Md

Did an operation precede death? No Date of

Was there an autopsy? Clinical

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) 865 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manchester Md. DATE OF BURIAL Dec 9 1922

20 UNDERTAKER W M Rockrow ADDRESS 2238 W Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69863

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D69863

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4506 Springdale ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peare Ann Bergen

(a) RESIDENCE. No. 4506 Springdale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. State statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12.3.22

7 AGE	Years	Months	Days	If LESS than 1 day, 10 hrs. or min.
	Foetal		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Geo L. Bergen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md

12 MAIDEN NAME OF MOTHER Ord A. Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co md

14 Informant Mrs Pearl A. Bergen (Address) 4506 Springdale ave

15 Filed DEC 8 - 1922 ROBT. R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 8. 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/3, 1922, to 12/8, 1922, that I last saw h.r alive on 12/8, 1922, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 6 mos. 4 ds.

CONTRIBUTORY (Secondary) Placenta Marginalis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. J. Turlington, M. D.

12/8 1922 Address) 102 E Hoffman ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem.

DATE OF BURIAL: 12/8 1922

20 UNDERTAKER: J. Fem McCully

ADDRESS: 130 E. Fort ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69864

CERTIFICATE OF DEATH.

161-002 D69864

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Homewood Hospital ST., 16 WARD)

2-FULL NAME Jane Shaw

(a) RESIDENCE No. 4198 N. Carrollton Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 3, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			4days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) DOR

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER H. T. Shaw

11 BIRTHPLACE OF FATHER (city or town) Jamestown Pa (State or country)

12 MAIDEN NAME OF MOTHER Sylvia Wood

13 BIRTHPLACE OF MOTHER (city or town) Bradford Pa (State or country)

14 Informant Henry T. Shaw (Address) 4198 N. Carrollton Ave

15 Filed DEC 8 - 1922 ROBERT H. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1922, to Dec. 7, 1922, that I last saw h[illegible] alive on Dec. 7, 1922, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Dystocia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) G. Lahiste Ewell, M. D.

12/8, 1922 (Address) 905 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Dec 8 1922

20 UNDERTAKER Wm J. McNeal & Sons

ADDRESS North Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69865

CERTIFICATE OF DEATH.

90 D69865

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 734 N. Gilmor ST., 19 WARD)

2-FULL NAME Betty H. Ingram

(a) RESIDENCE NO. 734 N. Gilmor ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. H. Ingram

6 DATE OF BIRTH (month, day, and year) Sept 14, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	75	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm C. Callahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Marya Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Fannie Morgan
(Address) 734 N. Gilmor St

15 Dec 8 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1922, to Dec 6, 1922, that I last saw h[illegible] alive on Dec 6, 1922, and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Senility

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M. Barnard, M. D.

Dec 7, 1922 (Address) 626 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gordon Park Cem — DATE OF BURIAL Dec 9 1922

20 UNDERTAKER Wm Tickner & Sons — ADDRESS North Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69866

D69866

CERTIFICATE OF DEATH.

46

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1623 N Gay - ST., 8 WARD)

2-FULL NAME Mollie V. Hagerty

(a) RESIDENCE NO. 1623 N Gay St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bernard C Hagerty

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years: 65 | Months: | Days: | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): D37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Wm H Brian

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Mary Linthicum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Bernard Hagerty
(Address) 1623 N Gay St

Filed DEC 8 - 1922, 19 .....

ROBERT R. KRAUTER
Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 6 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov ....., 1922, to Dec 6, 1922,

that I last saw her alive on Dec 6, 1922,

and that death occurred, on the date stated above, at 10 40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 4 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Mar 1918

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Growth Hoff, M. D.

Dec 1922 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 9 1922

20 UNDERTAKER: Wm J Eichner Sr — ADDRESS: Walbrook

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69867 D69867

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 Elmwood Road ST., 27 WARD)

2-FULL NAME Helen M. Wyatt

(a) RESIDENCE NO. 16 Elmwood Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3rd 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Alexander H. Wyatt

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah A. Wilson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va.

14 Informant Mrs. V. X. Hooper
(Address) 16 Elmwood Rd.

15 Filed Dec 8 - 1922 Robert P. Harrison Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1922, to Dec. 7, 1922, that I last saw her alive on Dec 6th, 1922, and that death occurred, on the date stated above, at 8.30A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
2. Uremic Poisoning

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Irvin Abell, M. D.

(Address) 846 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Dec 9 1922

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 Whitelock St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69868

CERTIFICATE OF DEATH

X 45

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard (St.) 4 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Brown

(a) RESIDENCE. No. Ellicott City St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffr

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Wm Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Lavinia [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hospital Records.

(Address)

15 Filed , 19 Robert P. Garrison, Registrar

8-1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/5 1922

17

I HEREBY CERTIFY, That I attended deceased from 11/27, 1922, to 12/5, 1922

that I last saw him alive on 12/5, 1922

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Leon Mendon M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Gilboa Cem. Balto Co.

DATE OF BURIAL: Dec. 10 1922

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69869

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69869

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST.: 7 WARD)

2-FULL NAME Jacob ~~Snyder~~ (Snyder.)

(a) RESIDENCE. NO. 530 N. Chester ST., 7 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Louisa ~~Snyder~~

6 DATE OF BIRTH (month, day, and year) Oct 9th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
63		1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory laborer. ~~Oil~~

(b) General nature of industry, business, or establishment in which employed (or employer) Southern Tan Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John B. ~~Snyder~~

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Marie Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Florence Snyder
(Address) 530 N. Chester St.

15 Filed Nov. 19 Robert P. Warfield Registrar

No. 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1922, to Dec 6, 1922, that I last saw him alive on Dec. 6, 1922, and that death occurred, on the date stated above, at 2-50 A m.

The CAUSE OF DEATH* was as follows:

Uremia.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertrophied prostate

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm. J. Fulton, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Dec. 9th 1922
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	400 S. Wolfe

Leave blanks be already supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 8

Spec.—1-10-21—M&T—1500 Bks.

D69870 HEALTH DEPARTMENT—CITY OF BALTIMORE D69870

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 Harford Ave. WARD) 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Honora G. Riley

(a) RESIDENCE NO. 1802 Harford Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry D. Riley

6 DATE OF BIRTH (month, day, and year): 11/22/1866

7 AGE: Years 55 Months 11 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Stayton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Stayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Harry Riley

(Address): 1802 Harford Ave.

15 8 mo 1922 Robert F. Harriger, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1922, to Dec 5, 1922,

that I last saw h-e alive on Dec 4, 1922,

and that death occurred, on the date stated above, at 1:10 A m.

The CAUSE OF DEATH* was as follows:

General Paresis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no clinical

What test confirmed diagnosis?

(Signed) F. D. Slingey M. D.

12/7, 1922 (Address) 2700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. DATE OF BURIAL: 12/9/22

20 UNDERTAKER: George J. Ruth ADDRESS: 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lucetic

Spec.—1-10-21—M&T—1500 Bks.

D69871

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69871

CERTIFICATE OF DEATH.

65-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 E. North Ave ST.) (8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A. Quast

(a) RESIDENCE NO. 1619 E. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma M. Quast

6 DATE OF BIRTH (month, day, and year): 9/19/1863

7 AGE: Years 59 Months Days

If LESS than 1 day... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Frank Quast

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mary Goss.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant (Address): Geo. J. Quast 1619 E. North Ave

15 Filed 19 Robert P. Harrison, Registrar

8-1922

Burial Permit Sent.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 7, 1922

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to Dec. 7, 1922,

that I last saw h[illegible] alive on Dec. 7, 1922

and that death occurred, on the date stated above, at 10. m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

(duration) 3 hrs.

CONTRIBUTORY (Secondary): Lymphatic Leukemia

(duration) about 3 years.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) Theodore H. Marrison M. D.

19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: 12/9/22

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 30 Harford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69872

CERTIFICATE OF DEATH.

90 D69872

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 N. Homberg ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel H Ball

(a) RESIDENCE. No. 627 N. Homberg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Laura A Ball deceased

6 DATE OF BIRTH (month, day, and year) Nov. 0-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work B & O R R

(b) General nature of industry, business, or establishment in which employed (or employer) Car Repair Man

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Wm H Ball
(Address) 627 Beaumont Ave

15 Filed Dec 8 1922 Robert P. Harrison, Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to Dec 7, 1922, that I last saw h[illegible] alive on Dec 7, 1922 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows: Uremia Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Dysentery

(duration) yrs. mos. 3 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

Dec 8, 1922 (Address) 835 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 9 1922

20 UNDERTAKER	ADDRESS
Mr & Mrs John W Pugh & Son	801 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION. AGE should be stated EXACTLY. PHYSICIAN'S should state TION is very important. See instructions on back of certificates.

8-1922

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69873 44 D69873

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Church Home & Hosp—

CITY OF BALTIMORE: (No. 1 Broadway ST., Fairmount 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mollie Haas

(a) RESIDENCE NO. 506 Invalids ST., WARD Hagers Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Haas

6 DATE OF BIRTH (month, day, and year) Feb 20th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	59	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hagerstown Md
(State or country)

PARENTS

10 NAME OF FATHER Jas Kuhn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Hagerstown Md

12 MAIDEN NAME OF MOTHER Mary S. Boyd

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Hagerstown Md

14 Informant Louis Haas
(Address) 506 Invalids Hagerstown

15 Filed Dec 8 19 22 Registrar

No. 1822

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec. 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1922, to Dec 8, 1922.

that I last saw her alive on 12/7/, 1922.

and that death occurred, on the date stated above, at 4:12 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Metastasis Liver & Lungs

(duration) yrs. 7+ mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Autopsy

(Signed) Gaylord Pavelton, M. D.

, 19 (Address) Colonial Home Bel Air

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL dec 11 1922

20 UNDERTAKER Robt Brookerson

ADDRESS Calhoun & Holins Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Feldhans) ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69874

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69874

129

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 N Pulaski ST. 15 WARD)

2-FULL NAME Mrs. Barbara Feldhans

(a) RESIDENCE. NO. 1810 N. Pulaski ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Feldhans

6 DATE OF BIRTH (month, day, and year) ? 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER J. D. Whitlock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs J. C. Edwards (Address) 1810 N Pulaski

15 1922 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1922, to Dec. 7, 1922, that I last saw her alive on Dec. 6, 1922, and that death occurred, on the date stated above, at 11½ A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) 10+ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Physical findings.

(Signed) A. F. Robinson, M. D.

12-8, 1922 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	12-9 1922
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun & Fayette Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

8-

Dup. [illegible] Permit Clerk

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69875

38

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 113 W. West St. 72 WARD)

2-FULL NAME Mary Thomas

(a) RESIDENCE. No. 113 W. West St. ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathaniel Thomas

6 DATE OF BIRTH (month, day, and year) May 5 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER David Shutter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Alice Scott

(Address) 105 W. West St.

15 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/8/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/5/ 1922, to 12/8/ 1922, that I last saw her alive on 12/7/ 1922, and that death occurred, on the date stated above, at 1.20 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis about 1 (? Syphilitic History)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? No Clinical Necessity

What test confirmed diagnosis?

(Signed) J. Sim Bowley, M. D.

12/8/ 1922 (Address) 908 S. Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	12-11- 1922

20 UNDERTAKER Chas. Henry Smith ADDRESS 1018 Pulaski St.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-
TION is very important. See instructions on back of certificates.

9-

Spec.—1-10-21—M&T—1500 Bks.

D69876

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69876

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1737 Orlean ST., 6 WARD)

2-FULL NAME Abraham Amos.

(a) RESIDENCE NO. 1737 Orlean ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cornelia Amos.

6 DATE OF BIRTH (month, day, and year): 1853

7 AGE — Years: 69 — Months: — — Days: — — If LESS than 1 day, hrs. or mtn.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hod Carrier

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Harford Co Md.

PARENTS

10 NAME OF FATHER: Abraham Amos

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Grace Ware

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Cornelia Amos. (Address): 1737 Orleans St.

15 Filed 1922, 19 Robert F. [illegible], Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-7-1922

17

I HEREBY CERTIFY, That I attended deceased from 11-18-, 1922, to 12-7-, 1922,

that I last saw h[illegible] alive on 12-6-, 1922,

and that death occurred, on the date stated above, at 7-P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

Indigestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W W Bevgill, M. D.

12-7, 1922 (Address) 611-N-Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Upper Cross Roads Harford Co. Md.

DATE OF BURIAL: Dec 11 1922

20 UNDERTAKER: Chas. N. Johnson

ADDRESS: 716 N. Caroline St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69877

CERTIFICATE OF DEATH.

100-001 D69877

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Madison St. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah White

(a) RESIDENCE NO. 1718 E. Madison St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry W. White.

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Rebecca Sweeney.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

11 Informant (Address) John C. Lauer. 1718 E. Madison.

18 Filed Robert P. Harrison, Registrar

9 m 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1922 to Dec 6, 1922

that I last saw her alive on Dec 6, 1922

and that death occurred, on the date stated above, at 6.18 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

1922 (Address) 600 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL Dec 9 1922

20 UNDERTAKER Lilly and Zeiler

ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D69878

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69878

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 621 S. Charles St. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Paulus. 25----------

(Residence in Baltimore: No. 621 S. Charles St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White.

5-Single, Married, Widow(er) or Divorced, (Write the word.): Single.

6-DATE OF BIRTH: February 27th. 1866. (Month) (Day) (Year)

7-AGE: 56 yrs. 9 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer,
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R. Co.

9-BIRTHPLACE, (State or Country): Germany.

PARENTS:

10-NAME OF FATHER, Frederick Paulus.

11-BIRTHPLACE OF FATHER, (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Magdeline Zimmer.

13-BIRTHPLACE OF MOTHER, (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ursula Anzer. (sister)

(Address) 1622 Patapsco St.

15-

Dec 9 1922 Robert P. Harrison

Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 7th. 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism,

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Dec 8th 1922. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Am. R. C. DATE OF BURIAL. Dec. 9 1922

20-UNDERTAKER, Michael Doyle ADDRESS 156 Lee St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69879

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69879

CERTIFICATE OF DEATH.

1 PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. Sandtiger & Lakewood St. 1823 ward) REGISTERED No. C

2 FULL NAME Henry P. Johnson

(Residence in Baltimore: No. 2135 McCulloh St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M.

4-COLOR OR RACE, C.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH ..... (Month) Unknown, ... (Day) 1 ..... (Year)

7-AGE, 23 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER H. P. Johnson Sr

11-BIRTHPLACE OF FATHER (State or Country) S.C.

12-MAIDEN NAME OF MOTHER Sara Canada

13-BIRTHPLACE OF MOTHER (State or Country), Ga

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. P. Johnson Sr

(Address) 2135 McCulloh

15-

Filed ..... 191... Registrar.

C 9 - 1922 Robert E. Lazenby

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 7, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Gun Shot wound through right Ear
Accidental
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
Dec 7, 1922 (Address) 2132 Rolandpark

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Dec. 10, 1922

20-UNDERTAKER James A. Dennis — ADDRESS 1303 Gresham st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69880

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1922 D69880

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Franklin St. Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Thomas Hayward

(Residence in Baltimore: No. 1163 N Mount St.; yrs., 18 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	colored	Married

6-DATE OF BIRTH, Not known 1.....
(Month) (Day) (Year)

7-AGE, 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) North Carolina

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER. (State or Country). Not known

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER. (State or Country). Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Sutch

(Address) 1153 N. Mount St

15-

Filed ..... 192.....

Robert P. Harrison,
Registrar.

C 9-1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 6 192 2
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or Inquiry.) find that said deceased came to Cause death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Base of Skull due to Bullet wound, also Lacerations from same Bullet

Homicide (Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage in Brain

(Duration) yrs. mos. ds.

(Signed) James M. Fenton M. D.
(Coroner.)

Dec 7 192 2 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

1153 N Mount St

Former or usual residence " "

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

~~Fayetteville North Carolina~~ Auburn Cem Dec 9 1922

20-UNDERTAKER. ADDRESS

James H. Dennis 1303 Greenmount Ave

is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D69881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69881

CERTIFICATE OF DEATH.

3/C

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (St.,) 1 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Jelenoski

(a) RESIDENCE No. 906 S. Decker st. St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 17th 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Jelenoski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Wislmck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M.T.H.

Robert P. Griffith,

15 12-9-1922 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21 1922 to Dec. 8 1922,

that I last saw him alive on Dec. 8 1922,

and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Frances L. Dodgheda M. D.

12-8-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Dec 12th 1922

20 UNDERTAKER Lilly & Zeiler. ADDRESS 403 N. Wolfe St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69882 D69882

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 W Barre ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Wistling

(a) RESIDENCE NO. 724 W Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie F Wistling

6 DATE OF BIRTH (month, day, and year) Jan 3 1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor at O&C

(b) General nature of industry, business, or establishment in which employed (or employer) Bartlett & Hayward Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER August Wistling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Groman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Annie F Wistling 724 W Barre st.

15 Filed Dec 9-1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 19[illegible], to Dec 7, 1922

that I last saw h alive on 19

and that death occurred, on the date stated above, at 9.30a m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eden Gresham, M. D.

12/8, 1922 (Address) 817 Fawn n.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Dec 11 1922

20 UNDERTAKER John H. Denny — ADDRESS 715 Light St

Spec.—1-10-21—M&T—1500 Bks.

Britton 1711 E. Balto

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69883

CERTIFICATE OF DEATH.

112

D69883

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 913 E. Biddle ST. 10th (WARD)

2-FULL NAME Margaret Christina Drager.

(a) RESIDENCE NO. 913 East Biddlee ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Henry Drager.

6 DATE OF BIRTH (month, day, and year): July 1, 1841.

7 AGE — Years: 81 — Months: 5 — Days: 7 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore City Maryland

PARENTS

10 NAME OF FATHER: George L. Bauer.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Margaret Blessing.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. L. H. Koff.

(Address) 913 East Biddlee st

15 1922 Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1922, to Dec 7, 1922, that I last saw h~~er~~ alive on December 7, 1922, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) E B Britton M. D.

Dec 8 1922 (Address) 1711 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmanuel Lutheran Lawnside — DATE OF BURIAL: 12/10 1922

20 UNDERTAKER: Geo. W. Lee & Son - 2503 Edmondson Ave — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69884

CERTIFICATE OF DEATH.

45 ✓ D69884

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital, ST.) 12 WARD)

2-FULL NAME Edward H Downing

(a) RESIDENCE NO. 2628 N Charles St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen A. Downing

6 DATE OF BIRTH (month, day, and year) Aug 17 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Freight Agent

(b) General nature of industry, business, or establishment in which employed (or employer) ~~Ft Bk~~ 186

(c) Name of employer Maryland Steamship Line

9 BIRTHPLACE (city or town) Brookline Mass
(State or country)

PARENTS

10 NAME OF FATHER Edward Downing

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Lexington Mass

12 MAIDEN NAME OF MOTHER Ellen Harrington

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Lexington Mass

14 Informant Mrs Helen A. Downing
(Address) 2628 N. Charles St

15 12-9-1922 Robert J. Harrison, Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/7/22

17 I HEREBY CERTIFY, That I attended deceased from 12/5/22 to 12/7/22.

that I last saw h~~im~~ alive on 12/7/22, 19 .....,

and that death occurred, on the date stated above, at 1855 p m.

The CAUSE OF DEATH* was as follows:

Surgical Shock

(duration) yrs. mos 11hrs ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? Yes Date of 12/6/22

Was there an autopsy? None

What test confirmed diagnosis? Clinical & Surgical Findings

(Signed) Jno A Scarpulla, M. D.

, 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boston Mass

DATE OF BURIAL Dec 9 1922

20 UNDERTAKER Jos Joerdens Son

ADDRESS 2178 Pace

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

160014
D69885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69885

CERTIFICATE OF DEATH.

X 44

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME Mrs. Marion Phair

(a) RESIDENCE No. Main, St. Laurel Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Phair

6 DATE OF BIRTH (month, day, and year) Nov 26 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	12	

8 OCCUPATION OF DECEASED House Wife

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Howard Brousdale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Malinda Starr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 9-1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8. 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 , 1922 to Dec 8 , 1922 , that I last saw her alive on Dec 8 , 1922 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) yrs. 13 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Dec 1

Was there an autopsy? Yes

What test confirmed diagnosis? Post-mortem

(Signed) F. L. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Buttonwood Md	Dec 11 1922
20 UNDERTAKER Geo E French	ADDRESS Laurel

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69886 D69886

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 S. Paca ST. 72 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Sakievich

(a) RESIDENCE. No. 622 S. Paca ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ Ellen Sakievich

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George J. Sakievich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Annie Muck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant William Sakievich (Address) 622 S. Paca St

15 Filed Robert P. Harrison, Registrar

1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1922.

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1921, to Dec. 8, 1922, that I last saw him alive on Dec. 7, 1922 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Tubercular laryngitis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchness, M. D.

, 19 (Address) 650 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec. 11. 1922

20 UNDERTAKER ADDRESS

John Grebliauckas F.D. 425 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D69887

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 W Lomberd St.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Naviokas

(a) RESIDENCE. No. 806 W Lomberd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) Nov. 1th 1920

7 AGE 2 Years 1 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ---

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Naviokas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Aiduktis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Anne Navioas (Address) 806 W Lomberd Street

15 Filed Dec 9 1922 Robert P. Harrison, Registrar

Physical Property Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1922 to Dec 8, 1922 that I last saw h[illegible] alive on Dec 8 1922; and that death occurred, on the date stated above, at 11. A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 6 wk mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) [illegible], M. D.

12/8 192 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec. 11. 1922
20 UNDERTAKER	ADDRESS
John Grebliauckas J.G.	425 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

HEALTH DEPARTMENT---CITY OF BALTIMORE

D69888

CERTIFICATE OF DEATH

D69888

44 REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2511 E Eaton ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A May

(Residence in Baltimore: No. 2511 E Eaton St.; 70 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word): Single

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1852 (Year)

7-AGE: 70 yrs. — mos. — ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Dress Maker
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (State or country): Not Known

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (State or country): Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs S. Hartman

(Address) 2511 E Eaton Av

15- Dec 1922 Robert P. Harrison, 191 REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 7, 1922, to, Dec 8 1922, that I saw her alive on Dec 8 1922, and that death occurred, on the date stated above, at 8a m.

The CAUSE OF DEATH* was as follows:

Renal Suppression
Abdominal Cancer,
Cardiac Collapse.

(Duration) ..... yrs ..... mos. ..... ds.

Contributory (SECONDARY) Carcinoma of Gall Bladder, Liver & Pancreas

(Duration) ..... yrs ..... mos. ..... ds.

(Signed) Carey L Thompson M. D.

12 8 1922 [Address] 2806 Eutaw

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: New Cathedral

DATE OF BURIAL: DEC 11 1922, 191

20-UNDERTAKER: Geo W Little

ADDRESS 2700 EDMONDSON AVE

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

9 1922

Spec. 1-10-21 M&T 1500 Blks.

D69889

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69889

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Municipal Hosp

CITY OF BALTIMORE: (NO. ..... ST., 26 WARD)

2-FULL NAME Mary M. Bauman

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas G Bauman

6 DATE OF BIRTH (month, day, and year): Sept 18 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	62	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): ? Md.

PARENTS

10 NAME OF FATHER: John Winchester

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md- Known

12 MAIDEN NAME OF MOTHER: Md- Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md- Known

14 Informant (Address): Bay View Asylum

15 Filed 9-1922 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-8-1922

17 I HEREBY CERTIFY, That I attended deceased from 8-9-, 1922 to 12-8-, 1922 that I last saw her alive on 12-8-, 1922 and that death occurred, on the date stated above, at 2:50 A m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 3 6 yrs. mos ds.

CONTRIBUTORY (Secondary) General Paresis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Wass. & S.F. & A. H.

(Signed) Clyde McNeil, M. D.

(Address) Municipal Hosp 12/8 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Md- Allied — DATE OF BURIAL: Dec. 11 1922

20 UNDERTAKER: H. Mc Cook — ADDRESS: 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Filed

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69890

CERTIFICATE OF DEATH.

129 D69890

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 Hartford Ave ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Johnson

(Residence in Baltimore: No. 718 Hartford Ave St.: 50 yrs.. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, ... (Month) — (Day) 1850 (Year)

7-AGE, 72 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer Odd

9-BIRTHPLACE, (State or Country), (

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Martha Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Parker

(Address) 718 Hartford Ave

15-

Filed....., 191.... Registrar.

12-9-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) 12 (Day) 7 (Year) 1922

17- I HEREBY CERTIFY, That I attended deceased from Nov. 29 1922, to Dec 7 1922, that I saw him alive on Dec 6 1922, and that death occurred, on the date stated above, at 2 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(Duration) ....yrs. 9 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) R. J. Young M. D.

12/7, 1922 (Address) 1729 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Dec. 12, 1922

20-UNDERTAKER Mrs Robert A. Elliott ADDRESS 715 Ashland Ave

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69891

CERTIFICATE OF DEATH.

31

D69891

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 726 McHenry st. (ST.) 17 (WARD)

2-FULL NAME John Fogarty, Jr.

(a) RESIDENCE NO. 726 McHenry st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work produce dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Fogarty

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Sarah Benton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Mrs. sarah Miles, 760 McHenry st.

15 Filed 9-1922 Robert F. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1922, to Dec. 6, 1922, that I last saw him alive on Dec. 6, 1922, and that death occurred, on the date stated above, at 8.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Delaglisia M. D.

12-7-22 (Address) 37 E. North avenue.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL Dec 11th 1922

20 UNDERTAKER John J. Cowan & Son per F. J. Cowan ADDRESS 701 Holliday St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69892 | CERTIFICATE OF DEATH. | 131 D69892

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 Sterling St ST., 10 WARD)

2-FULL NAME John C Little

(a) RESIDENCE NO. 721 Sterling St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Elizabeth Little

6 DATE OF BIRTH (month, day, and year): Aug-15-1855

7 AGE: Years 67 Months 2 Days 20

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Winchester Md

PARENTS

10 NAME OF FATHER: John Little

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs Hattie Jenkins 721 Sterling St

15 Filed DEC 9 - 1922 Robert F Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1922 to Dec 5 1922, that I last saw h[illegible] alive on Dec 5 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Failure of cardiac compensation & Kidney trouble with Dropsy

(duration) ..... yrs. 4 mos. 1 ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis (duration) ..... yrs. 4 mos. ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Urinary Examination

(Signed) Geo S Hall M. D.

1922 (Address) 426 E 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery Baltimore Md

DATE OF BURIAL: 12/9 1922

20 UNDERTAKER: Samuel J Kemsley

ADDRESS 5[illegible] N Eddle St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69893 HEALTH DEPARTMENT—CITY OF BALTIMORE D69893

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016-N-Charles ST., VV WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Julius Huggins

(a) RESIDENCE NO. 2016-N-Charles ST., 12 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 93 yrs. 9 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Eliza Huggins

6 DATE OF BIRTH (month, day, and year) Feby-14-1829

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	93	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired from

(b) General nature of industry, business, or establishment in which employed (or employer) Iron & Steel Business

(c) Name of employer F. J. Huggins

9 BIRTHPLACE (city or town) Lexington

(State or country) Kentucky

PARENTS

10 NAME OF FATHER Wm. Huggins

11 BIRTHPLACE OF FATHER (city or town) not known

(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Mary Sanders

13 BIRTHPLACE OF MOTHER (city or town) not known

(State or country) England

14 Informant Mr. James N. Huggins

(Address) 2016-N-Charles St

15 Filed Dec 7, 1922 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1922, to Dec 7, 1922

that I last saw h alive on Dec 6, 1922

and that death occurred, on the date stated above, at 4-45 P m.

The CAUSE OF DEATH* was as follows:

Heart disease

Acute Dilitation Heart (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical exam.

(Signed) Dr. H. B. Lamb M. D.

Dec. 1922 (Address) 2105 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Dec 9, 1922

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 103 W. NORTH AV

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

9 - 1922

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69894

D69894

129

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 22 WARD)

2-FULL NAME John Baker

(a) RESIDENCE NO. 30 S. Green St. ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records. (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

Robert P. Garrison, Clerk

Burial Permit 10720

12-9-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6 1922

17 I HEREBY CERTIFY, That I attended deceased from December 2, 1922, to December 6, 1922, that I last saw him alive on December 6, 1922, and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Phenomena

(Signed) Clyde Brooks M. D.

12/6/1922 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 9 1922 19

20 UNDERTAKER Commissioner Health.

ADDRESS

Pat. Wm. E. WOODALL.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D69895

CERTIFICATE OF DEATH.

74-001 D69895

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 822 N Carrollton av ST. 16 WARD.

2-FULL NAME Kate Sturgis

(a) RESIDENCE. No. 822 N. Carrollton av ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 30 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Snow Hill
(State or country) md

PARENTS

10 NAME OF FATHER John O. Sturgis

11 BIRTHPLACE OF FATHER (city or town) Snow Hill
(State or country) md

12 MAIDEN NAME OF MOTHER Eliza Nelson

13 BIRTHPLACE OF MOTHER (city or town) Snow Hill
(State or country) md

14 Informant miss mary C. Robb Supt
(Address) 822 N. Carrollton ave

15 Filed Dec 9-1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 3 1922, to Dec 8 1922,
that I last saw h[illegible] alive on Dec 8 1922,
and that death occurred, on the date stated above, at 11.30 P.M.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy & Left Hemiplegia

about seven days
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Carlton M. Cooke, M. D.
Dec 9, 1922 (Address) 1107 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 11 1922
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69896

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69896

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Moses

(a) RESIDENCE NO. 545 Mosher st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Nathanial Moses

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M. T. H.

15 Robert F. Carrick, 12-7-22 19

Registrar

9-1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 6, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1922, to Dec. 6, 1922,

that I last saw him alive on Dec. 6, 1922,

and that death occurred, on the date stated above, at 7.05 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis L. Badagliacca, M. D.

(Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Dec 9th 1922

20 UNDERTAKER Harry C. Wright — ADDRESS 1364 Rc ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69897 D69897

CERTIFICATE OF DEATH.

10

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 640 S. Lakewood Ave. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward E. Ulsch.

(Residence in Baltimore: No. 640 S. Lakewood ave. St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	single

6-DATE OF BIRTH, April 27th, 1911.
(Month) (Day) (Year)

7-AGE, 11 yrs. 5 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School attendant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Sebastian N. Ulsch.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Elizabeth Sullivan

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sebastian N. Ulsch.

(Address) 640 S. Lakewood Ave

15- Dec. 1922, Robert P. Harrison, 191.....
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 9th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6 1922, to Dec 9 1922, that I saw h[illegible] alive on Dec 8 1922, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Tonsils adenoids

(Duration) ....yrs. ....mos. 7 ds.

(Signed) E. L. Loy M. D.

Dec 9, 1922 (Address) 270 Cantrell

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, Dec. 10th, 1922

20-UNDERTAKER Lilly & Zeiler ADDRESS 409 S. Wolfe St

C. important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69898 D69898

CERTIFICATE OF DEATH.

113

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 W. North ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis E. Kemp

(Residence in Baltimore: No. 1512 W. North St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH, Nov (Month) 19 (Day), 1911 (Year)

7-AGE, ... yrs. ..... mos. 11 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Child

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER Irving Kemp

11-BIRTHPLACE OF FATHER (State or Country). Frederick Md

12-MAIDEN NAME OF MOTHER Mary A Wardall

13-BIRTHPLACE OF MOTHER (State or Country) Lynchburg Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irving Kemp

(Address) 1512 W. North

15- Robert P. Harrison,

Dec 9 1922 ....., 191.....

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 9 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 8 1922, to Dec 9 1922, that I saw her alive on Dec 9 1922, and that death occurred, on the date stated above, at 9.15 A m.

The CAUSE OF DEATH* was as follows:

Hemophilia

Hemorrhage from umbilicus

12 hrs.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Jaundice (Gastroduodenitis)

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Chas. D. Kahn M. D.

Dec 9, 1922 (Address) 910 N. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. M. E. Christ Frederick Md

DATE OF BURIAL. Dec 9 1922

20-UNDERTAKER Wm Cook

ADDRESS 502 E North

Important. See instructions on back of certificate.

9

Spec.—6-9-19—H. F. Co.—1000 Bks.

D69899

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-601 D69899

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 858 Vine St. St.: 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Jones

(a) RESIDENCE. No. 858 Vine St. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER David Wallace

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Victoria Jones

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed DEC 10 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 4, 1922, to Dec 8, 1922, that I last saw h.[illegible] alive on Dec 8, 1922, and that death occurred, on the date stated above, at 5 00 A m.

The CAUSE OF DEATH* was as follows:

Prematurity
(31 Wks Foetus)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. Norwood Wilson, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int. Dom Cemetery	12/10/22
20 UNDERTAKER	ADDRESS
Wm. G. H. Hooper	906 W. Conway

69900A D69900

HEALTH DEPARTMENT—CITY OF BALTIMORE

69900 D69900

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1103 Division St. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Robt. E. Cole

(Residence in Baltimore: No. 1103 Division St. St.; 45 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widow or Divorced. (Write the word.)
male	colored	Married

6-DATE OF BIRTH. about ....., 1877
(Month) (Day) (Year)

7-AGE. 24 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... work.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Tenn.

PARENTS.

10-NAME OF FATHER, Robt. Cole

11-BIRTHPLACE OF FATHER, (State or Country), Tenn.

12-MAIDEN NAME OF MOTHER, Martha Crow

13-BIRTHPLACE OF MOTHER, (State or Country). Tenn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Davis Wagner

(Address) 1103 Division St

15- Filed DEC 10 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 8, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Hennessy M. D.
(Coroner.)

Dec 9 1922 (Address) 2802 Eutaw Pl

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Johnson City Tenn	Dec 9 1922
20-UNDERTAKER	ADDRESS
David Taylor	Balto

is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69901

CERTIFICATE OF DEATH.

100-00 D69901

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 Bolton ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Davis

(a) RESIDENCE. No. 1528 Bolton ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~ Widowed, ~~or Divorced~~ (write the word): Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Edward Graham Davis

6 DATE OF BIRTH (month, day, and year): 1834-3-9

7 AGE: Years 88 Months 9 Days 15 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Boston Mass

PARENTS

10 NAME OF FATHER: Leonard Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Boston Mass

12 MAIDEN NAME OF MOTHER: Lydia Beauberton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dresden Maine

14 Informant (Address): John C. Davis 1528 Bolton St

15 Filed DEC 10 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1922, to Dec 9th, 1922, that I last saw h[illegible] alive on Dec 8th, 1922, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(She has had asthma & Emphysema for many years)

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary): Cardiac asthenia

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs in chest.

(Signed) Gordon Wilson, M. D.

Dec 9, 1922 (Address) 49 Preston St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem Cambridge Mass.	12-11 1922
20 UNDERTAKER	ADDRESS
Sturges Jenkins & Sons Co	Eutaw & Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69902 100-001 D69902

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5 Merryman Court ST. 17 WARD)

2-FULL NAME Nathalie Coates Thomas Whiting

(a) RESIDENCE. No. 5 Merrymans Court ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of G W C Whiting

6 DATE OF BIRTH (month, day, and year) Apr. 20 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER J Marshall Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Gregg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. W Whiting

(Address) Continental Bldg.

15 FILED DEC 10 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 6th, 19 22, to Dec 8th, 19 22;

that I last saw h.. alive on Dec 8th, 19 22;

and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Septicaemia

Pelvic Cellulitis

(Puerperal in nature)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Otitis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of Nov 29th

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. B. Gamble Jr. M. D.

, 19 (Address) 26 W Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Dec 11th 19 22

20 UNDERTAKER Henry Jenkins & Son Co

ADDRESS McCulloh & Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69903

24-001 D69903

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 N poppelton ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Peterson

(a) RESIDENCE NO. 17 N poppelton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Benjamin Munik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Mat Sicuart 17 N poppelton st.

15 DEC 10 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1922, to Dec 9 1922, that I last saw h~~er~~ alive on Dec 8 1922, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

apoplexy + Hemiplegia

Coma

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at her home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? observation

(Signed) Joseph A Geckler M. D.

Reg 1922 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Washington Rd. DATE OF BURIAL Dec 10 1922

20 UNDERTAKER Max Feinman ADDRESS 1127 Bolton St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69904

D69904

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2132 W. North Ave ST., 15 WARD)

2-FULL NAME MORRIS BLUMBERG

(a) RESIDENCE NO. 2132 W North Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 35 yrs. ... mos. ... ds.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
MALE	white	MARRIED

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of LEAH BLUMBERG

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work SHOE MAKER

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) RUSSIA

PARENTS

10 NAME OF FATHER NATHAN Blumberg

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Baltimore St

15 Filed DEC 10 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-9 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6th 1922 to Dec. 9 1922 that I last saw him alive on Dec 9th 1922, and that death occurred, on the date stated above, at 10 20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis and arterio sclerosis

(duration) 15 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Apoplexy (duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Benj. Rosadow M. D.

12-10 1922 (Address) 2306 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cem Wash Road — DATE OF BURIAL 12/10 1922

20 UNDERTAKER Jack Lewis 1439 E Baltimore St — ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69905

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Hebrew Hosp

CITY OF BALTIMORE: (No. Monument St. St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Alpert

(a) RESIDENCE. NO. Lubber St. ST., WARD. Sumpter St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Alpert

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Zahman Alpert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Baltimore

15 Filed DEC 10 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/8 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 20th, 1922, to Dec 8th, 1922,

that I last saw h alive on Dec 8th, 1922,

and that death occurred, on the date stated above, at 6 20 p.m.

The CAUSE OF DEATH was as follows:

General Asthenia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/20/22

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. Bolley Sondheimer, M. D.

12/8, 1922 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Herzl Frendship Cem	12/10 1922
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69906

CERTIFICATE OF DEATH.

38 D69906

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Meyer

(a) RESIDENCE. No. Mt Hope Retreat ST. 28 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? Born Known yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mr Meyer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	ab 45 -	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) (?) Bohemia

PARENTS

10 NAME OF FATHER (?) Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country) " "

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Md.

15 Filed DEC 10 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7, 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 27th, 1921, to Dec 7, 19 xx.

that I last saw h er alive on Dec. 7, 1922.

and that death occurred, on the date stated above, at 7.05 P m.

The CAUSE OF DEATH* was as follows:

Paralysis - R. Hemiplegia (Cause?)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Melancholia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David A. Flamm, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Dec. 11 1922
20 UNDERTAKER Eby & Geiler.	ADDRESS Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D69907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D69907

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 827 S. Third ST., 26 WARD)

2-FULL NAME Margaret Hippler

(a) RESIDENCE, No. 827 S. Third ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 8 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ignatius M. Hippler

6 DATE OF BIRTH (month, day, and year): March 19, 1856

7 AGE

Years	Months	Days	If LESS than 1 day, ..hrs. or min.
66	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

037

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John Hartmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wolf Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Ignatius M. Hippler

(Address) 827 S. Third St.

15 Filed DEC 10 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1st, 1922, to Dec. 8th, 1922, that I last saw her alive on Dec. 8th, 1922, and that death occurred, on the date stated above, at 12.45 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ted L. Lockwood M. D.

, 19 (Address) 1806 E. Third St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Dec. 11 1922

20 UNDERTAKER: Tilly & Zeiler

ADDRESS: 803 Lafayette

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69908

CERTIFICATE OF DEATH.

REGISTERED NO. 118 - D69908

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Univ. Hospital (St.:) (Ward) 11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene W Stoplains.

(a) RESIDENCE. No. 797 W. St Annapolis Md WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. E. W. Stoplains

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Henry Stoplains

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nennette Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hospital Records

15 Filed DEC 10 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 29 1922 to Dec 10 1922

that I last saw h im alive on Dec 10 1922

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov 29, 1922

Was there an autopsy? No

What test confirmed diagnosis? Operation & phys. findings

(Signed) G. Estalling, M. D.

Dec 10 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md	Dec 10 1922
20 UNDERTAKER B L Hopping	ADDRESS Annapolis Md

Spec.—1-10-21—M&T—1500 Blks.

D69909

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69909 — 49 — D69909

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Sterrett ST., 21 WARD)

2-FULL NAME William Lee Davis

(a) RESIDENCE NO. 1023 Sterrett ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? 69 yrs. 8 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Sarah J Davis

6 DATE OF BIRTH (month, day, and year) March 17-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... O'Ls

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer Wampole

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mrs. Sarah J. Davis
(Address) 1023 Sterrett st

15 Filed DEC 10 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/8 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1920, 19 , to Dec 8 , 1922.

That I last saw h in alive on Dec 8 — 1922.

and that death occurred, on the date stated above, at 11:10 a. m.

The CAUSE OF DEATH* was as follows: Sarcoma Gran the dura mata, and Brain.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? yes Date of Jan. 1920

Was there an autopsy? no

What test confirmed diagnosis? Appearance & Microscopic findings

(Signed) Geo H Phillips, M. D.

, 19 (Address) 2300 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Dec 11 1922

20 UNDERTAKER James Dignan & Son — ADDRESS 1000 S. Paca St

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69910

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 D69910

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Gertrude Toomis

(Residence in Baltimore: No. 764 W. Hamburg st St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widow, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Dont Know (Month) 1..... (Day) (Year)

7-AGE. 24 Yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Edw Groshans

11-BIRTHPLACE OF FATHER, (State or Country). Pa

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country). " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw Groshans

(Address) 764 W Hamburg St

15-

Filed DEC 10 1922 192.....

ROBERT R. KRAUTER, Burial Permit Clerk. Register.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 8 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, as ~~Coroner on~~ Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Burns on body

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W X Tomach M. D. (Coroner.)

12-8 1922 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cemetery

DATE OF BURIAL. Dec 11 1922

20-UNDERTAKER. James Dignan & Son

ADDRESS 1000 S. Pacast

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69911 D69911

CERTIFICATE OF DEATH.

38

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Georgia Richards

(Residence in Baltimore: No. 817 Dopp St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~Single, Married,~~ Widowed, ~~or Divorced,~~ (Write the word.)
Female	Black	

6-DATE OF BIRTH. Dec 15 1886
(Month) (Day) (Year)

7-AGE. 35 yrs. 11 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laundry
(b) General nature of industry, business, or establishment in which employed (or employer). at John Hopkin

9-BIRTHPLACE, (State or Country). Balt

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hopkin Hospital

(Address) N. Broadway.

FILED DEC 10 1922 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 6 192.2
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Arterial Occlusion
Mitral Stenosis
Aortic Insufficiency

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

12-8 1922 (Address) 518 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery.	Dec. 11 1922
20-UNDERTAKER.	ADDRESS
George F. Ruth.	1735 Hayford Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Ferdinand Dettell ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69912

CERTIFICATE OF DEATH.

90 D69912

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009- E. Oliver ST., 9 WARD)

2-FULL NAME Ferdinand Dettell

(a) RESIDENCE NO. 1009. E Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? 62 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~. (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late Margaret Dettell

6 DATE OF BIRTH (month, day, and year) Oct. 19/1835

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
87.	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. 015

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER M. Wasta. Dec 6

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. John Davis (Address) 1009 E. Oliver St

15 Filed DEC 10 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1 1919, to Dec. 8 1922,

that I last saw ~~him~~ her on Dec. 8 1922

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 4 yrs. 5 mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. E. Rumbold M. D.

Dec 6 19 22 (Address) 1531 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baeckmann Cem

DATE OF BURIAL 12/11/22

20 UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69913

HEALTH DEPARTMENT—CITY OF BALTIMORE

128 D69913

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 318 N Strieker ST.; 14 WARD)

2-FULL NAME Joseph Johnson

(a) RESIDENCE. NO. 318 N Strieker ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lizzie Johnson

6 DATE OF BIRTH (month, day, and year) 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER ✓

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lettie Pease

(Address) 1732 McCulloh St

15 Filed DEC 10 1922 19 ROBERT R. KRAUSE Registrar

Burial Permit Clerk.

Mad 1403-B

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 27, 1922, to Nov 6, 1922

that I last saw h alive on Nov Dec 6 1922

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Ac Uremia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ac Parenchymatous Nephritis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Exposure at work

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Caw Short, M. D.

12/6, 1922 (Address) 1812 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 10 1922
20 UNDERTAKER David Easton	ADDRESS 916 E Lan

MAKE STRONG OR CARBON COPY. Answer all questions. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition

Spec.—1-10 21 M&T 1500 Bks.

D69914

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D69914

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 E. Henrietta St. ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard C. Wentworth Jr.

(a) RESIDENCE NO. 21 E. Henrietta St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 30 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Howard C. Wentworth Sr

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ruth E. Cottingham

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Howard C. Wentworth Sr.
(Address) 21 E. Henrietta St.

15 Filed DEC 10 1922, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/9 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/4, 1922, to 12/9th, 1922, that I last saw him alive on Dec. 9th, 1922, and that death occurred, on the date stated above, at 4 15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia following influenza

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) Convulsions 2 hours

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Weibel M.D.

12/10, 1922 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk Cem.

DATE OF BURIAL 12/11 1922

20 UNDERTAKER S. F. McCauley

ADDRESS 130 E. Front

DEC 10 1922 ROBERT P. KRAUTER, Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated in YEARS. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Ritter ✓ D69915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69915 D69915

CERTIFICATE OF DEATH.

90 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2235 Brenck Ave ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah L. Ritter

(a) RESIDENCE NO. 2235 Brenck Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Ritter

6 DATE OF BIRTH (month, day, and year) Nov 1st 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Crispin Pfeffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gutenmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John F. Ritter (Address) 2235 Brenck Ave

15 Filed DEC 10 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 2- 1922, to Dec 7 1922,

that I last saw h[e] alive on Dec 5- 1922,

and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1-7 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. Campbell Smith M. D.

(Address) 11 W Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick City Cemetery DATE OF BURIAL Dec 11 1922

20 UNDERTAKER E. B. Whitmore & Co ADDRESS Frederick Md

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. Name also CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69916 HEALTH DEPARTMENT—CITY OF BALTIMORE D69916

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1238 Battery Ave ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Plitt

(a) RESIDENCE NO. 1238 Battery Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Christian Plitt

6 DATE OF BIRTH (month, day, and year) Apr 7 - 1831

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	91	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Stut

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Pauline Plitt (Address) 1238 Battery Ave

15 Filed DEC 10 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1922

17 I HEREBY CERTIFY, That I attended deceased from 1910, 19 . to Dec 7, 1922.

that I last saw her alive on Dec 6, 1922,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Myocarditis

Ch. Interstitial Nephritis

(duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary) Ac. Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Geo A Straus M. D.

12/9, 1922 (Address) 1800 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL Dec 11 1922

UNDERTAKER F. B. Wippert

ADDRESS 225 E Fred Ave

Information should be carefully supplied. AGE should be stated EXACTLY. Abbreviations of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Queen

D 69917

HEALTH DEPARTMENT—CITY OF BALTIMORE

24

D69917

D69917

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1723 Orchard ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Lumm

(Residence in Baltimore: No. 1723 Orchard St.; ....yrs.,....mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, 11/1/92, 1 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs....mos. 9 ds.	....hrs. or....min?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Edward Lumm

11-BIRTHPLACE OF FATHER (State or Country), Balto. City

12-MAIDEN NAME OF MOTHER Jennie Richardson

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Lumm

(Address) 1723 Orchard St.

15- DEC 10 1922 191.... Burial Permit Clerk.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 9th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 8th 1922, to Dec 9th 1922, that I saw h alive on Dec. 9th, 1922, and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Tetanus

(Duration) ....yrs....mos. 3 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) A. Lee Eller M. D.

Dec 10, 1922 (Address) 724 Mad. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Dec 10, 1922
20-UNDERTAKER Daniel Easton	ADDRESS 916 Druid Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 69918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69918

9 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Ray

(a) RESIDENCE NO. 1316 Riggs Ave. Balto. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced — WIFE (or) HUSBAND of

6 DATE OF BIRTH (month, day, and year): June 22, 1922.

7 AGE — Years: — Months: 5 Days: 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer: " "

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

PARENTS

10 NAME OF FATHER: Ralph Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Lillian Blossom

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Y. City N.Y.

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 Filed DEC 10 1922 ROBERT M. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1922. to Dec 7 1922. that I last saw her alive on Dec 7 1922. and that death occurred, on the date stated above, at 7.00 A. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) — yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary): Influenzal pneumonitis

(duration) 4 yrs. — mos. 2? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bacterial culture

(Signed) H. A. Weech, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Dec 10 1922

20 UNDERTAKER: Edward Ruggold — ADDRESS: 463 N Eu

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

69919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69919

REGISTERED NO.

1-PLACE OF DEATH 5423 Park Heights Ave

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretta Agnes Mullen.

(a) RESIDENCE NO. 1136 Chelton Ave. Pittsburg, Pa. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred - yrs. 1- mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57.	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hazlin (State or country) Pa.

PARENTS

10 NAME OF FATHER John Mullen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Scherry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Leo G. Mullen (Address) Pittsburg, Pa.

15 Filed DEC 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1922, to Dec 10, 1922 that I last saw h-e alive on Dec 10, 1922 and that death occurred, on the date stated above, at 7:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis,

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myo Cardial Insufficiency.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home Pittsburg Pa.

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Clinical

(Signed) Bradley & Wood M. D.

12/10/1922 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crafton, Pa.	12/10/22 19
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Via Penn. R. R. Escort, Leo G. Mullen

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69920

CERTIFICATE OF DEATH.

D69920

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 Mc Culloh St. 11 WARD)

2-FULL NAME Daisy Moseley

(a) RESIDENCE. NO. 908 Mc Culloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Clarence Moseley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Jordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. Co. Md

11 Informant (Address) Margaret Moseley 908 Mc Culloh St

15 Filed DEC 11 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 — 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 6 — 19 22 to Dec 8 — 19 22

that I last saw her alive on Dec 8 — 19 22,

and that death occurred, on the date stated above, at 1 a — m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Measles —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Post examination

(Signed) Samuel R Dair, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12/11 19 22
20 UNDERTAKER	ADDRESS
Samuel Hawley	1128 Edmondson Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69921

CERTIFICATE OF DEATH.

100-001 **D69921**

1-PLACE OF DEATH Boy View Hospital

CITY OF BALTIMORE: NO. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Richardson

(a) RESIDENCE NO. 1237 Druid Hill Ave ST.

WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) General 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant Boy View Hospital (Address) Baltimore Md.

15 Filed DEC 11 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1922

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1922 to Dec 8 1922

that I last saw h alive on Dec 8 1922

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Bacteriological

(Signed) A. J. O'Donnell M. D.

12/9/1922 (Address) Boy View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Ave DATE OF BURIAL 12/11 1922

20 UNDERTAKER Edward A. Kennedy ADDRESS 578 N. Eutaw St.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69922

CERTIFICATE OF DEATH.

100-001 D69922

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 Pearl St 4 ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucia Grelli

(Residence in Baltimore: No. 208 Pearl St St.; ..... yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. fem

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, March 2nd (Month) (Day), 1922 (Year)

7-AGE, ... yrs. 9 mos. 6 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of ~~industry~~, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Alessandro Grelli

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Caterina Marzetti

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caterina Grelli

(Address) 208 E Pearl St

DEC 11 1922

Filed ....., 191... ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8th (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 6th 1922, to Dec 8th 1922, that I saw h er alive on Dec 8th 1922, and that death occurred, on the date stated above, at 12 p m.

The CAUSE OF DEATH* was as follows:

broncho pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) capillary bronchitis

(Duration) 10 yrs. 1 mos. 3 ds.

(Signed) C. L. Sexton M. D.

....., 191... (Address) 210 Pearl St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Vincent Cem. DATE OF BURIAL, 12/10/22, 191...

20-UNDERTAKER Geo. J Ruth ADDRESS 1125 Hanford

Spec.--1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69923

D69923

CERTIFICATE OF DEATH.

159-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 W Fratt St., 20 WARD)

2-FULL NAME Edw E Macguire

(a) RESIDENCE NO. 1907 W Fratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Wh

5 Single, Married, Widowed, or Divorced. (Write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27 1902

7 AGE Years 12 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER Francis A Macguire

11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)

12 MAIDEN NAME OF MOTHER Mary E Gregg

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Francis A. Macguire (Address) 1907 W. Fratt St.

15 Filed DEC 11 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-9 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1922 to Dec 9, 1922.

that I last saw h alive on Dec 9, 1922

and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Fracture of Femur Oblique

Left Thigh

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen A Strauss M. D.

, 19 (Address) 1527 Columbia ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Dec. 11 1922

20 UNDERTAKER George L. Schwab ADDRESS 901 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Name should be entered IN FULL. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69924

CERTIFICATE OF DEATH.

161-002 D69924

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 S. Bethel ST., 2 WARD)

2-FULL NAME Stanislaus Tuczynski

(a) RESIDENCE NO. 712 S. Bethel ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 6 hours ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10 1922

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Michael Tuczynski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Catharine Wieczorek

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Michael Tuczynski
(Address) 712 S Bethel Street

15 Filed DEC 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1922, to Dec 10, 1922, that I last saw ~~him~~ alive on Dec 10, 1922, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Difficult Labor

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. —

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John H. Rohberger M. D.

19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus — DATE OF BURIAL Dec 11 1922

20 UNDERTAKER John M Weber — ADDRESS 1803 Bank St

IMPORTANT.—Physicians should be careful to supply ALL items called for. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69925 HEALTH DEPARTMENT—CITY OF BALTIMORE **D69925**

CERTIFICATE OF DEATH.

175

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3531 Benson St. ST., 13 WARD)

2-FULL NAME Ruth C. Enos

(a) RESIDENCE NO. 3531 Benson St ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (Write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 15-1920

7 AGE — Years: 2 — Months: 6 — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Richard E. Enos

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Catharine M. Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Richard E. Enos (Address) 3531 Benson St

15 FILED DEC 11 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 9 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 7, 1922, to Dec 9, 1922,

that I last saw h alive on Dec 9 - 1922, 19

and that death occurred, on the date stated above, at 3 45 A. m.

The CAUSE OF DEATH* was as follows:

Pleumonia Poeumonia

over

H. Coroner Freeman

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. J Davis, M. D.

Dec 11 1922 (Address) 800 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ly Mayr (Hampden)

DATE OF BURIAL: Dec. 11 1922

UNDERTAKER: Horace F. Burgee

ADDRESS: 3631 Falls Rd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

By some food that could not determine what

Spec.—1-10-21—M&T—1506 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69926

CERTIFICATE OF DEATH.

135

D69926

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3660 Parkdale Ave. ST., 13 WARD)

2-FULL NAME Reuben Gladfelter

(a) RESIDENCE NO. 3660 Parkdale Ave. ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed or divorced, HUSBAND of (or) WIFE of: Elizabeth J. Gladfelter

6 DATE OF BIRTH (month, day, and year): April 17-1832

7 AGE: Years 90 | Months 8 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Contractor and
(b) General nature of industry, business, or establishment in which employed (or employer): Builder
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Maryland

PARENTS

10 NAME OF FATHER: Joseph Gladfelter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Miss Celia M. Gladfelter
(Address): 3660 Parkdale Ave.

15 Filed DEC 14 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 9- 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1922, to Dec 9, 1922, that I last saw him alive on Dec 9, 1922 and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Retention of Urine, due to Hypertrophied Prostate;

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Shock + age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Prowse W. Hall, M. D.

12/10. 1922 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Dec. 12 1922

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 363 Forest Rd.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69927 CERTIFICATE OF DEATH X 74-001 D69927

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Homewood Hospital 2724 N. Charles St. (ST.) 12 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore O. W. Mackee

(a) RESIDENCE NO. 104 Hilton Ave. ST., ... WARD Catonsville
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29th 1851

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
71	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Md.

PARENTS

10 NAME OF FATHER Charles Mackee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Hannah Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Amelie Mackee
(Address) 104 Hilton Ave.

15 Filed DEC 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1922, to Dec 10, 1922,
that I last saw h/ alive on Dec 10, 1922,
and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy & Hemiplegia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Coma (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) (M. D.) S. W. Crushing, M. D.

12/11 1922 (Address) 714 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Dec 12, 1922

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N. Bond St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69928

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69928

CERTIFICATE OF DEATH.

188-003

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Eastern Ave & Clinton St. No. WARD)

REGISTERED No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth McMasters

(Residence in Baltimore: No. 3421 Eastern Ave

W 35 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May 22 (Month) (Day), 1869 (Year)

7-AGE, 53 yrs. 6 mos. 16 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Scotland

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Scotland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Douglas McMasters

(Address) 3421 Eastern Ave

15- Filed DEC 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 8th (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull, the result of being accidentally knocked down by an Automobile

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D. (Coroner)

Dec 10th 1922 (Address) Curtis Bay Md.

*State the DISEASE CAUSING DEATH, or in violent cases (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn Cem

DATE OF BURIAL, Dec 11, 1922

20-UNDERTAKER Louis Heemann

ADDRESS 226 Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

1922
50
872

D69929 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D69929 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 Biddle Ave, ST., 16 WARD)

2-FULL NAME Samuel Smith

(a) RESIDENCE No. 1202 Biddle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Smith

6 DATE OF BIRTH (month, day, and year) Mar 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50 ~~7~~	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hostler

(b) General nature of industry, business, or establishment in which employed (or employer) 624

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sallie Smith

(Address) 1202 Biddle Ave

15 Filed DEC 11 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 7th, 1922, to Dec 9th, 1922, that I last saw him alive on Dec 8th, 1922, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Emphysema

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

12/10, 1922 (Address) 1837 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Dec 12th 1922

20 UNDERTAKER Charles Coleman — ADDRESS Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 - M&T - 1500 Bks.

Sam Lewis

D69930 HEALTH DEPARTMENT—CITY OF BALTIMORE D69930

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam Lewis

(a) RESIDENCE NO. 906 McDonough ST., WARD

(Usual place of abode) Mc Donough M

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE: Years 73 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laber

(b) General nature of industry, business, or establishment in which employed (or employer): OHO

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North carolin

PARENTS

10 NAME OF FATHER John Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant (Address): Hop Record

15 Filed DEC 11 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 8 - 1922

17 I HEREBY CERTIFY, That I attended deceased from 12 - 1 - 1922 to 12 - 8 - 1922

that I last saw h[illegible] alive on 12 8 1922

and that death occurred, on the date stated above, at 10 PM m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Alfred C Morrell M. D.

12/9 1922 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery

DATE OF BURIAL: DEC 12 1922

20 UNDERTAKER: R E Grost

ADDRESS: 1405 McElderry

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D69931

D69931

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 614 N. Central Ave St. 5 WARD)

2-FULL NAME Farina Jones

(a) RESIDENCE NO. 614 N. Central Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Jones

6 DATE OF BIRTH (month, day, and year): 1857

7 AGE: Years 65 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General domestic

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): St. Mary's Co. Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Betsy Summerville

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St. Mary's Co Md

14 Informant (Address): Howard Jones 614 N. Central Ave

15 DEC 11 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1922, to Dec. 8, 1922, that I last saw her alive on Dec. 7, 1922, and that death occurred, on the date stated above, at 6:9 a. m.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Senumtes Jaundice

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jas. C. Robinson M.D.

(Address) 632 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery — DATE OF BURIAL: Dec 11 1922

20 UNDERTAKER: R. C. Cross — ADDRESS: 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

Gruber

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69932 — 162 — D69932

CERTIFICATE OF DEATH.

REGISTERED NO....

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No E. Monument ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby (boy) Gruber

(a) RESIDENCE NO. 800 W. Franklin st ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year) 10-7-22

7 AGE — Years: X — Months: — Days: 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: X

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town), (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Gruber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Fannie Gruber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) Jack Lewis 1439 Ebaltst

15 Filed DEC 11 1922 19

ROBERT R. KRAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1922, to Dec 9, 1922, that I last saw h\ alive on Dec 9, 1922, and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Hemorhage Neonatorum

(duration) yrs. mos. 3 hrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Ulceration of stomach

(Signed) Ernest Edlavitch, M. D.

12-9, 1922 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Wash Road

DATE OF BURIAL: 12/11 1922

20 UNDERTAKER: Jack Lewis 1439 E Balto

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69933

CERTIFICATE OF DEATH.

185 D69933

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 3 WARD)

2-FULL NAME ~~(No.)~~ Daniel Coffey.

(a) RESIDENCE NO. 921 Granby, ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60.	5	11.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ship watcher.
(b) General nature of industry, business, or establishment in which employed (or employer) 62
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York State

PARENTS

10 NAME OF FATHER James Coffey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Jas L Foard
(Address) 175 Gay St

15 Filed DEC 11 1922 ROBERT P. KRAUTER, Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1922 to Dec 10, 1922.
that I last saw h[illegible] alive on Dec 9, 1922,
and that death occurred, on the date stated above, at 2 00 A. m.
The CAUSE OF DEATH* was as follows: Broncho Pneumonia
(fell on way to hosp. for treatment
7 pneumonia).

CONTRIBUTORY (Secondary) (duration) 4 yrs. 7 mos. 8 ds.

18 Where was disease contracted if not at place of death? over

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym & Signs

(Signed) [illegible] M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenly Cem DATE OF BURIAL Dec 11 1922

20 UNDERTAKER Wm Cook ADDRESS 502 E North

N. B. WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69934 **D69934**

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1735 N. Carolina ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Belle Wilson Busick

(a) RESIDENCE NO. 1735 N. Carolina ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry C. Busick

6 DATE OF BIRTH (month, day, and year) June 17 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife. 57

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: David Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr. Harry C. Busick

(Address) 1735 Hanford ave

15 Filed DEC 17 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1922, to Dec. 10, 1922, that I last saw h 21 alive on " 9 1922 and that death occurred, on the date stated above, at 10.40 a. m.

The CAUSE OF DEATH* was as follows:

Central Apoplexy

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cerebral Paralysis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George A. Hartman M. D.

Dec 10, 1922 (Address) 2214 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Dec. 13 1922

20 UNDERTAKER: Henry Storck Son — ADDRESS: 1301 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

D69935 HEALTH DEPARTMENT—CITY OF BALTIMORE D69935

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1404 Harford Ave ST., 9 WARD)

2-FULL NAME Lena Wolf

(a) RESIDENCE NO. 1404 Harford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard Wolf

6 DATE OF BIRTH (month, day, and year) March 25 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER Wm Fritz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant Mr Leonard Wolf
(Address) 1404 Harford ave

15 Filed ....., 19 ..... ROBERT R. KRAUTER, Registrar
DEC 11 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1922

17 I HEREBY CERTIFY, That I attended deceased from December-9-1922, to December-9, 1922, that I last saw her alive on December 9 1922 and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure + Exhaustion
(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? physical examination

(Signed) William H. Stewart, M. D.

12/10, 1922 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Dec. 12 1922

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Lager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69936

Dec. 4-10-21 M&T—1500 Bks.

D69936

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Joseph's Hosp. 13 ST., WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Mary Kelly

(a) RESIDENCE NO. 2469 Druid Hill Ave ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Records of St Joseph's Hospital Carolina + Hoffman Sts

15 FILED: DEC 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 9, 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1922 to Dec. 9, 1922

that I last saw h[illegible] alive on Dec. 9, 1922

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Auricular Fibrillation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) G. J. Kruger, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: Dec 12 1922

20 UNDERTAKER: Henry Storck Son — ADDRESS: 130 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69937

D69937

CERTIFICATE OF DEATH.

90

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 Falls Road ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwin Daniel Holtz

(Residence in Baltimore: No. 1037 Falls Road St.; ....yrs.,....mos.....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	M

6-DATE OF BIRTH, May 15, 1868
(Month) (Day) (Year)

7-AGE, 54 yrs. 6 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 031

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Edwin D. Holtz

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Barbara Bebo

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin D. Holtz

(Address) 934 Woodlawn Ave

15- DEC 11 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 12 1922, to December 10 1922, that I saw h im alive on December 10 1922, and that death occurred, on the date stated above, at 11:20 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Fatty Degeneration Chronic Endocarditis

(Duration) ....yrs....mos....ds.

(Signed) Frank H. Martin M. D.

Dec 10 1922 (Address) 1037 Falls Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Pinelawn Cem Balto Co.	Dec. 13, 1922.
20-UNDERTAKER	ADDRESS
Martin Feeley Son	827 W North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D69938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D69938

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1245 Edward St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ellis

(Residence in Baltimore: No. 1245 Edward St.; yrs. 1 mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug (Month) ..., 1848 (Day) (Year)

7-AGE, 74 yrs. 3 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) H

9-BIRTHPLACE, (State or Country) Balto, M.D.

PARENTS.

10-NAME OF FATHER, Samuel Waters

11-BIRTHPLACE OF FATHER (State or Country), Snow Hill Md.

12-MAIDEN NAME OF MOTHER Eliza Colluck

13-BIRTHPLACE OF MOTHER (State or Country), Snowhill Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliza Robbins

(Address) 755 Hicks St. Philadelphia

15-

Filed DEC 11 1922 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 9 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1922, to Dec 9 1922, that I saw h er alive on Dec 9 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cardio - nephritis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. ds.

(Signed) R. J. Young M. D.

12/9, 1922. (Address) 1729 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Cedar Lawn Cemetary

DATE OF BURIAL, DEC 12, 1922

20-UNDERTAKER, Jos. T. H. Rochester

ADDRESS 1413 Jefferson st

D69939

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69939

CERTIFICATE OF DEATH. 74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 514 N. Eutaw St. St. M Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rufus Taylor

(Residence in Baltimore: No. 514 N. Eutaw St. St.; yrs. ..... mos. ..... ds.)

D.K.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	D.K.

6-DATE OF BIRTH. about 1867
(Month) (Day) (Year)

7-AGE. about.
55 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... unknown
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Roanoke, Va.

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. W. Dist. Police

(Address) Penna. Ave.

15- Filed DEC 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 9, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) unknown

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Dec 11 1922. (Address) 2. 80 Lanvale Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Roanoke Va	Dec 11th 1922

20-UNDERTAKER.	ADDRESS
A. Jones	111 S. Gilmor

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69940

CERTIFICATE OF DEATH. X 24 90

D69940

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 231 Warren Ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Frederick W. Beckwith.

(Residence in Baltimore: No. 231 Warren Ave. St.; yrs...., mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Do not know.

6-DATE OF BIRTH. Do not know. ..... 1..... (Month) (Day) (Year)

7-AGE. 48 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 15

9-BIRTHPLACE, (State or Country). Florida.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. C. Hutton.

(Address) 231 Warren Ave.

15-Filed DEC 11 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 5th. 1922 ....., 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquiry ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) inquiry ..... find that said deceased came to ..... his ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Dec 9th 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. .....mos. .....ds. In the State..... yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Edgewood Cem	Dec 9 th, 19 22
20-UNDERTAKER. J. F. Tighe & Son	ADDRESS 1318 Light St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69941 CERTIFICATE OF DEATH. 100-001 **D69941**

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Ashland Ave ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Heath

(a) RESIDENCE NO. 1215 Ashland av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 7 1918

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
4	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Elmer Heath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Francis Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md.

14 Informant Mr Heath

(Address) 1215 Ashland Ave

15 Filed DEC 11 1922 19 Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9 1922.

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1922, to Dec 9, 1922,

that I last saw him alive on Dec 9, 1922,

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

over

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. F. Costello, M. D.

, 19 (Address) 335-2 31st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 12 1922
20 UNDERTAKER	ADDRESS
Frank A. Fink	2164 E. [illegible] St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary.

Spec.—1-10-21—M&T—1500 Bks.

D69942

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69942

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3719 Fleet St. ST., 76 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Gleich

(a) RESIDENCE NO. 3719 Fleet St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Bartholomew Gleich

6 DATE OF BIRTH (month, day, and year) July 29- 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	74	4	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Fiddt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. George Burken (daughter)
(Address) 3719 Fleet St.

15 DEC 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1922, to Dec 8, 1922, that I last saw her alive on Dec 7, 1922, and that death occurred, on the date stated above, at 8:50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Mitral Insufficiency
(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Dilated Heart
(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) M J McAvoy, M. D.
Dec 10, 1922 (Address) 839 S. Eldonridge

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Dec 13 1922

20 UNDERTAKER Lobb & Zuber

ADDRESS 403 S. Wolfe St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D69943

D69943

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No.) ..... ST., (WARD) .....

2-FULL NAME Henry A. Fahamenann

(a) RESIDENCE NO. 3714 Gough ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Fahamann

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Self-employed

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Ellis White

(Address) 2370 Madison Ave

15 Filed DEC 11 1922 ROBERT R. KRAUTER Registrar

Burial Permit Issued .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1922 to Dec 10 1922

that I last saw h[illegible] alive on Dec 10 1922

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. A. Fahamenann M. D.

19 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Dec 13 1922

20 UNDERTAKER W. J. Sadler's Sons

ADDRESS Norman

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69944

CERTIFICATE OF DEATH.

100-001

D69944

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1708 N. Chapel ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Elmer James

(a) RESIDENCE NO. 1708 N Chapel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 27-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER James James

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Libbie A Shupe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Jane James

(Address) 1708 N Chapel St

15 DEC 11 1922 ROBT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1922, to Dec. 10, 1922.

that I last saw him alive on Dec. 9, 1922,

and that death occurred, on the date stated above, at 9¼ a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

over

(duration) — yrs. — mos 17 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby M. D.

12/19 1922 (Address) 1223 N. Carolina st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL Dec. 12 1922

20 UNDERTAKER Wm Cook — ADDRESS 502 E Lan Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary.

Spec.—1-10-21—M&T—1500 Bks.

D69945 HEALTH DEPARTMENT—CITY OF BALTIMORE D69945

CERTIFICATE OF DEATH. 74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 W. Laurale ST., 16 WARD)

2-FULL NAME Johanna Huggelmyer

(a) RESIDENCE No. 1710 W Laurale St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Huggelmyer

6 DATE OF BIRTH (month, day, and year): Jan 21-1861

7 AGE: Years 61 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Herman Owen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dautkuss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Josephine Huggelmyer (Address): 1710 W Laurale

15 Filed DEC 11 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec. 9, 1922, that I last saw h[illegible] alive on Dec. 9, 1922, and that death occurred, on the date stated above, at 8 50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green, M. D.

12-10, 1922 (Address) 120 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwarz Cemetery	Dec. 12 1922
20 UNDERTAKER	ADDRESS
Lee Cook	501 E Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69946

CERTIFICATE OF DEATH.

129 D69946

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824½ W Lombard ST., 18 WARD)

2-FULL NAME Gustav F. C Pieper

(a) RESIDENCE NO. 824½ W Lombard ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Augusta Pieper

6 DATE OF BIRTH (month, day, and year): July 3 1840

7 AGE: Years 79 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinetmaker

(b) General nature of industry, business, or establishment in which employed (or employer): 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Herman Pieper
(Address) 824½ W Lombard

15 Filed DEC 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1922, to Dec 9 1922, that I last saw h in alive on Dec 9 1922, and that death occurred, on the date stated above, at 630 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis, arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) S. Lee Magnus, M. D.

12, 10, 19 (Address) 1065 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — DATE OF BURIAL: Dec 12 1922

20 UNDERTAKER: Wm Cook & Son — ADDRESS: 501 E North

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69947

D69947

CERTIFICATE OF DEATH.

57

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 E Eager ST., 10 WARD)

2-FULL NAME Louise K. McCubbin.

(a) RESIDENCE NO. 1736 E Eager ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 24, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Frank

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Long

13 BIRTHPLACE OF MOTHER (city or town) Fred'k Co.
(State or country) Md.

14 Informant Lillian McCubbin
(Address) 1736 E Eager

15 DEC 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 9, 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1922 to Dec. 9, 1922.

that I last saw her alive on Dec. 9, 1922.

and that death occurred, on the date stated above, at 7 15 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Edwin B. Fenby, M. D.

12/11/1922 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn; DATE OF BURIAL: Dec 17, 19 22

20 UNDERTAKER: Wm. Cook, 507 E. North ave. ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69948

D69948

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 482 Homeland ave ST. (WARD) 27

2-FULL NAME Annie Crawford

(a) RESIDENCE NO. 482 Homeland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of P. W. Crawford

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE: Years 74; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret L Hill

(Address) 482 Homeland ave

15 Robert F. Carrison, Registrar

C 111922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 1922.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22. 1922. to Dec. 10 1922.

that I last saw her alive on Dec. 9 1922

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Interstitial Nephritis

Duration (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Haas, M. D.

12,10,1922 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Govans Presbyterian Cemetery — DATE OF BURIAL: Dec 12th 1922

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument

I certify that the information given above is correct to the best of my knowledge and belief. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69949

D69949

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 S Kenwood Av ST.; 1 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Fuech

(Residence in Baltimore: No. 619 S. Kenwood Av St.; 78 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, January 16, 1844 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
81 yrs. 11 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. P. Ruckelhaus

(Address) 619 S. Kenwood Av

15-

1 1922 Robert P. Harrison, M.D.
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 30 1922, to Dec 10 1922, that I saw her alive on Dec 9 1922, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edgar Fuller M. D.

Dec 10, 1922 (Address) 2739 Eastern Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Dec 12, 1922

20-UNDERTAKER	ADDRESS
Peter Nicolaus	2000 Eastern Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69950

D69950

CERTIFICATE OF DEATH.

46

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 523 S Burley ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Josephine V Rego

(a) RESIDENCE. NO. 523 S Burley ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Luis Fontaini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Palomina Amaro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Martin V Dupont (Address) 218 E Lanvale St

15 DEC 1 1922 Robert F. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1922 to Dec 1, 1922

that I last saw h[illegible] alive on Dec 1 1922

and that death occurred, on the date stated above, at 1130 m.

The CAUSE OF DEATH* was as follows:

[illegible]

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Uterus

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of April 10 22

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Path.

(Signed) [illegible], M. D.

, 19 (Address) 20 S. E. Ave W.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec 13 1922
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

mation should be carefully supplied. All E should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69951 HEALTH DEPARTMENT—CITY OF BALTIMORE D69951

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Cor Lombard & Greene ST., 17 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Samuel Lee Perry

(a) RESIDENCE NO. 562 Greenmillow ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		One		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Lee

11 BIRTHPLACE OF FATHER (city or town) D. C.
(State or country)

12 MAIDEN NAME OF MOTHER Edith Simon

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hospital Record
(Address)

15 Filed ..... 19..... Registrar

Dec 1 1922 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 24 1922 to Nov. 30 1922

that I last saw him alive on Nov. 30 1922

and that death occurred, on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis
Prematurity

(duration) yrs. 1 mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Findings

(Signed) R B Jones M. D.

12/1 1922 (Address) Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL DEC 1 1922

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69952

CERTIFICATE OF DEATH.

129 D69952

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

2-FULL NAME Emma Bailey

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
71	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 DEC 11 1922 Robert E. Carraben, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 7 19 22

17 I HEREBY CERTIFY, That I attended deceased from December 1, 19 22 to December 7, 19 22.

that I last saw her alive on December 7, 19 22.

and that death occurred, on the date stated above, at 6 P.M. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Claude Moore, M. D.

12/8/1922 (Address) Municipal Hosptial.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 11 1922 19

20 UNDERTAKER Commissioner Health.

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69953

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69953

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST.) WARD)

2-FULL NAME Frank Wazeski

(a) RESIDENCE NO. 313 Chapel st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Wazeski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records Robert L'Hommedieu.

15 Dec 11 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1921, to Dec. 8, 1922, that I last saw him alive on Dec. 7, 1922, and that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum. X-ray

(Signed) Francis L. Dadeglucci M. D.

12-8-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

8 11 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69954

D69954

CERTIFICATE OF DEATH.

164

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 113 Gorsuch Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Schaefer

(a) RESIDENCE. NO. 113 Gorsuch Ave ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Schaefer

6 DATE OF BIRTH (month, day, and year) Dec. 25, 54.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Beer Cooker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sylvia Lloyd (Address) 913 Gorsuch

15 Filed Nov 1 1922 Robert P. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to Nov 1, 1922

that I last saw h[illegible] alive on Nov 1, 1922

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Influenza

2d age

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) W. T. Campbell M. D.

Nov 1, 1922 (Address) 1244 Linwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Gen. DATE OF BURIAL: Nov 4 1922

20 UNDERTAKER: E. Schoenmann Son ADDRESS 1039 Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 11 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69955

D69955

CERTIFICATE OF DEATH. X 126

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME Mrs. Linnie Kaufman

(a) RESIDENCE No. R.F.D. #2. Holsopple, Pa ST., WARD Holsopple Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nathaniel Kaufman husband

6 DATE OF BIRTH (month, day, and year): Dec. 2, 1878

7 AGE: Years 44 Months 0 Days 9. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer): (H)

(c) Name of employer: (H)

9 BIRTHPLACE (city or town) (State or country): (H) Pa.

PARENTS

10 NAME OF FATHER: Stephen Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): (H) Pa.

12 MAIDEN NAME OF MOTHER: Amanda ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): (H) Pa.

14 Informant (Address): JOHNS HOPKINS HOSPITAL Records

15 Filed 11 1922, 19 Robert P. Haffner, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 11, 1922.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1922. to Dec 11, 1922.

that I last saw her alive on Dec. 11, 1922.

and that death occurred, on the date stated above, at 5 45 a. m.

The CAUSE OF DEATH* was as follows:

Generalized peritonitis

Terminal bronchio-pneumonia

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) Pelvic abscess, fecal fistulae (acute - operation) 2 yrs. mos ds.

18 Where was disease contracted if not at place of death? Holsopple, Pa

Did an operation precede death? Yes Date of 12-6-22

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Eugene L. Shaw M.D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johnstown Penna

DATE OF BURIAL: Dec 11 1922

20 UNDERTAKER: William C. Black 927 W. Broadway

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(See affadavit over) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69956

D69956

CERTIFICATE OF DEATH.

145-003

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Concetta Vatale Maimone

(Residence in Baltimore: No. 413 Colvin St 26 St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word) Married

6-DATE OF BIRTH, June (Month) 15th (Day) 1879 (Year)

7-AGE, 43 yrs. 5 mos. 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Nova Di Sicilia Italy

PARENTS

10-NAME OF FATHER, Giuseppi Vatale

11-BIRTHPLACE OF FATHER, (State or Country) Nova Di Sicilia Italy

12-MAIDEN NAME OF MOTHER, Maria Poffini

13-BIRTHPLACE OF MOTHER, (State or Country) Nova Di Sicilia Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Salvatore Samuel Maimone

(Address) 413 Colvin St.

15- Filed DEC 7 1922 Robert P. Harrison, 192 Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 10 (Day) 192 7 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock — Hemorrhage

Burns (Hospital Shock)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chest Wall - Amputation

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

12 11 192 7 (Address) 508 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart & Cem. DATE OF BURIAL, 12/11/27 19

20-UNDERTAKER, Geo J. Ruth ADDRESS 1735 Harford Ave

18—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 69956

Baltimore, Md. May 1, 1924.

(Solvatore Maimone) Personally appeared before me this first day of May, 1924 Samuel Maimone, who made oath in due form of law, that the following information, not given on Baltimore City Health Department Certificate of Death - D69956, is true and correct; and that same should be added to the record of death of Concetta Maimone, whose death is recorded on said certificate.

Name of Deceased - Given on Certificate as Concetta Maimone.
Record Should Read - Concetta Vatale.Maimone.

Birthplace of Deceased - Given on Certificate as "Italy".
Record should read - Novora Di Sicilia.

Name of Father - Given On Certificate - "Unknown"
Record should read - Guisseppi Vatale.
Birthplace of Father - Given on Certificate - "Italy"
Record should read - Novora Di Sicilia.
Maiden Name of Mother - Given on Certificate - "Unknown"
Record should read - Maria Poffmi..
Birthplace of Mother - Given on Certificate - "Italy"
Record should read - Novora Di Sicilia.

Salvatore Maimone
Signature (Husband)

Rud Gaither
Notary Public.

D69957 HEALTH DEPARTMENT—CITY OF BALTIMORE D69957

CERTIFICATE OF DEATH.

188-003

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Franklin Square Hospital 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Benjamin F. Swindell

(Residence in Baltimore: No. 3304 Ridgewood Ave St.; 6 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Married

6-DATE OF BIRTH. Feb 1868
(Month) (Day) (Year)

7-AGE. 54 yrs. 10 mos.....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer). Journeyman

9-BIRTHPLACE, (State or Country) North Carolina

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Swindell

(Address) 3304 Ridgewood Ave

15- Robert F. Carraher,

Filed ..... 192.....

1922 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Comp. fracture lower jaw, R. femur, 4 ribs R. tibia & fibula & head also. Crushed chest Automobile accident

(Duration) .....yrs. ..... mos. 3 hrs

CONTRIBUTORY (Secondary) Internal Hemorrhage

(Duration) .....yrs. ..... mos. 3 hrs

(Signed) James M. Fowler M. D.
(Coroner.)

Dec 11 1922 (Address) 700 E Chase St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents.)
At place of death.....yrs.....mos. 3 hrs. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....
South Caty St

Former or usual residence 3304 Ridgewood

19-PLACE OF BURIAL OR REMOVAL, Balto Cem DATE OF BURIAL, Dec 13 1922

20-UNDERTAKER, Ehrensperger & Son ADDRESS Chestnut St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69958 HEALTH DEPARTMENT—CITY OF BALTIMORE D69958

CERTIFICATE OF DEATH. 179

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME. Thomas P. Parks

(Residence in Baltimore: No. 1944 Ridgewood Ave St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Single

6-DATE OF BIRTH. March (Month) 21 (Day) 1848 (Year)

7-AGE. 74 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto. City

PARENTS.

10-NAME OF FATHER. Frank J Parks

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Dorothy Ridgely

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Frank J. Parks

(Address). 1944 Ridgewood Ave

15- Robert P. Harrison,

Filed DEC 11 1922 192.... Registrar.

Burial Permit Given.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 10 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to Ct death on the day stated above.

The CAUSE OF DEATH* was as follows:

Scalds over body from falling in Tub Hot water accident

(Duration).....yrs.....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) James M Fenlon M. D. (Coroner.)

Dec 11 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos. 10 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

1934 Ridgewood Ave

Former or usual residence 1944 Ridgewood Ave

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Md	Dec 12 1922

20-UNDERTAKER. Chenoweth & Son ADDRESS Chestnut Ave

D69959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69959

CERTIFICATE OF DEATH.

90

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3500 Cedar ave ST. 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME George H. Harris

(Residence in Baltimore: No. 3500 Cedar ave St., 50 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 26 (Month) (Day), 1858 (Year)

7-AGE, 64 yrs. 5 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Machinest
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER Wesley Harris

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie J. Harris

(Address) 3500 Cedar Ave

15-

Filed ..... 191.....

Robert P. Harrison, Registrar.

Burial Permit Given

DEC 11 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular disease of heart

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) John H. Monnett M. D. (Coroner.)

Dec 13 1922 (Address) 3632 Roland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Dec 13 19 22

20-UNDERTAKER Chenoweth Son

ADDRESS Chestnut ave

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69960

D69960

CERTIFICATE OF DEATH.

159-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1236 Delwood Ave. WARD 13)

2-FULL NAME Charles Francis Alexander

(a) RESIDENCE NO. 1236 Delwood Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31. 1922

7 AGE — Years: — Months: 4 — Days: 7 — If LESS than 1 day, ...hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Walter S Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Gladys R Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address) Walter S. Alexander 1236 Delwood Ave

15 Filed ..... 19 ..... Robert P. Garrison, Registrar

DEC 1 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1922

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1922 to Dec. 8, 1922

that I last saw h[illegible] alive on Dec. 8, 1922

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Hydrocephaloid

(duration) yrs. 4 mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. F Coughlin M. D.

19 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: Dec 12 1922

20 UNDERTAKER: Chenoweth & Son — ADDRESS: Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69961

CERTIFICATE OF DEATH.

D69961

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 10 Railroad ST., Wilkens Ave WARD 25

2-FULL NAME Margaret S Nicholas

(a) RESIDENCE NO. 104 Redwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Nicholas

6 DATE OF BIRTH (month, day, and year) Feb 8th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Tiergarten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas Nicholas 104 Redwood ave (Address)

15 Filed DEC 12 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10. 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to Dec 10, 1922,

that I last saw h[illegible] alive on Dec 9, 1922

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Senility. Pulmonary Tuberculosis, Tuberculosis of Liver

(duration) Months

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis?

(Signed) Norvell Nitch M. D.

12/14/22 (Address) 2151 Wilkens ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Dec 15 1922

20 UNDERTAKER J B Hepplett ADDRESS 2234 Eastern ave

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D69962

REGISTERED NO.

D69962

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Sorrell

(a) RESIDENCE NO. 937 McCullough St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Sorrell

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
72	--		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md. (State or country)

PARENTS

10 NAME OF FATHER Henderson Sorrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Henrietta Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore, Md.

14 Informant Municipal Hospital Records. (Address)

15 Filed DEC 12 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 19 22

17 I HEREBY CERTIFY, That I attended deceased from December 3, 19 22, to December 10 19 22, that I last saw him alive on December 9, 19 22, and that death occurred, on the date stated above, at 1:15 A.M.

The CAUSE OF DEATH* was as follows:

(a) Cirrhosis of Liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

12/12/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 12/12/22

20 UNDERTAKER Samuel Kennedy

ADDRESS 37 N Caddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69963 HEALTH DEPARTMENT—CITY OF BALTIMORE D69963

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 Woodward ST., 21 WARD)

2-FULL NAME Maggie Schwartz

(a) RESIDENCE NO. 821 Woodward ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Schwartz

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE 59 Years — Months — Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hous Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) ------ 437

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Joseph ADoms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Vnknow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ------

14 Informant William Schwartz
(Address) 821 Woodward st.

15 Filed DEC 12 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10. th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18. 1922 to Dec 10. 1922
that I last saw h[illegible] alive on Dec 10. 1922
and that death occurred, on the date stated above, at 11th P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis
(duration) yrs. mos. 22 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) John L. Meadowcroft M. D.
12/11. 1922 (Address) 638 Wash Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec. 13th 19 1922

20 UNDERTAKER: John Grebliauckas J.G. — ADDRESS: 425 S Paca ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69964 CERTIFICATE OF DEATH. 129 **D69964**

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Sharp ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Camphor

(a) RESIDENCE NO. 906 Sharp ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 045

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thomas Camphor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nancy —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sloman Hall

(Address) 906 Sharp St

15 Filed DEC 12 1922 ROBERT R. KRAUTER, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 9, 1922, to Dec 10, 1922,

that I last saw h[illegible] alive on Dec 9, 1922,

and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Subacute Nephritis

(duration) yrs. 5 mos [illegible] ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H S McCall, M. D.

12/11, 1922 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Dec 13 '22

20 UNDERTAKER John N. Toadvine — ADDRESS 172 Mosher

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Parenchymatous
Nephritis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69965 HELTH DEPARTMENT—CITY OF BALTIMORE D69965

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 52 W Hamburg ST.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie L. Martin

(a) RESIDENCE. NO. 17 W. Hamburg ST. 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATTICAL PARTICULARS

3 SEX: F

4 COLOR OR RAC: Col.

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edw Molock.

6 DATE OF BIRTH (month, day, and year): Feb 5. 1885

7 AGE: Years 37 Mons 10 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): General Housework

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John H. Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Frozier Nickens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Sophia Martin 536 W. Pres St.

15 DEC 12 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/9/ 19 22

17 I HEREBY CERTIFY, That I attended deceased from 12/4/ 19 22 to 12/9/ 19 22 that I last saw h fr alive on 12/9/ 19 22 and that death occurred, on the date stated above, at 9 00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis about Probably 3 Or 4 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Errors in diet (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Microscop

(Signed) John Bowles M. D.

12/11/ 22 19 (Address) 1908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: Dec. 13 19

20 UNDERTAKER: John H. Toadvine

ADDRESS 143 Hotel Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-003 D69966

Registered No. C.....

1-PLACE OF DEATH Provincial Dead or

City of BALTIMORE: (No. Franklin Square Hosp St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William M. Lady

(Residence in Baltimore: No. 1010 Seven Mile Lane Pikesville St., etc., 21 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M.	W.	Married

6-DATE OF BIRTH, Unknown 1849
(Month) (Day) (Year)

7-AGE, 73 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Nothing
(b) General nature of industry, business, or establishment in which employed (or employer) disable

9-BIRTHPLACE, (State or Country). Washington D.C.

PARENTS.

10-NAME OF FATHER, Thos P. Lady

11-BIRTHPLACE OF FATHER, (State or Country) Washington D.C.

12-MAIDEN NAME OF MOTHER, Minnie Findley

13-BIRTHPLACE OF MOTHER, (State or Country) Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm M. Lady

(Address) 1010 Seven Mile Lane Pikesville

15- DEC 12 1922 ROBERT R. KRAUTER,

Filed ..... 192 ..... Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10th 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows: Pistol shot wound through Chest Collapsing Lung & Base of Brain while driving in automobile accident (Duration) Sudden ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) John M. Feulner M. D. (Coroner.)

Dec 11, 1922 (Address) 700 E. Chase

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
National Cem	Dec 15th 1922

20-UNDERTAKER	ADDRESS
John F. Coyne & Son Carl J. Causse	901 Madison Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69967 D69967

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

2-FULL NAME Eby Kurch

(a) RESIDENCE NO. Unknown ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) .....

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) (State or country) .....

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

Unable to obtain further history.

14 Informant ..... (Address) Municipal Hospital Records.

15 DEC 12 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 19 22

17 I HEREBY CERTIFY, That I attended deceased from October 13, 19 22, to December 10 19 22.

that I last saw him alive on December 9, 19 22,

and that death occurred, on the date stated above, at 3:00 A.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No Autopsy

What test confirmed diagnosis? .....

(Signed) Clyde A. Heck M. D.

12/11/22 (Address) Municipal Hospital.

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Hill Cemetery DATE OF BURIAL Dec 12 1922

20 UNDERTAKER George L. Schwab ADDRESS 1701 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69968

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69968

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home-Infirmary ST., 6 WARD)

2-FULL NAME Elizabeth Page Harrold.

(a) RESIDENCE NO. Church Home-Infirmary ST., 6 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 63 yrs. 8 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rev. James A. Harrold.

6 DATE OF BIRTH (month, day, and year) March-13-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Alexandria,
(State or country) Virginia.

PARENTS

10 NAME OF FATHER Rev. J. Pinkney Hammond

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Catherine Page

13 BIRTHPLACE OF MOTHER (city or town) Alexandria
(State or country) Virginia.

14 Informant Mr. Wm. M. Plummer, (nephew)
(Address) 3120-N-Calvert-St. City.

15 Filed DEC 12 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 5 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 . 19 22 . to Dec 9 . 19 22 .
that I last saw her alive on Dec. 8. . 19 22 .
and that death occurred, on the date stated above, at 7 P.M. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos 4 ds.
CONTRIBUTORY (Secondary) Hypostatic pneumonia
(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical Methods

(Signed) Gaylord Gaultier M. D.
19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL LOUDON PARK CEMETERY — DATE OF BURIAL Dec-12-22

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 103 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69969 46 D69969

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 331 Potomac Ave (ST.) Brooklyn (WARD)

2-FULL NAME Lelia E Huber

(a) RESIDENCE No. 331 Potomac Ave ST.,

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Huber

6 DATE OF BIRTH (month, day, and year) Nov 3 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	52	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) King & Queen Co Va

PARENTS

10 NAME OF FATHER Nathan Longest

11 BIRTHPLACE OF FATHER (city or town) King & Queen Co (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Jeffers

13 BIRTHPLACE OF MOTHER (city or town) King & Queen Co (State or country) Va

14 Informant Mrs Mary McLane

(Address) Edgewater P.O. Md

15 Filed DEC 7 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1922, to Dec, 1922, that I last saw h— alive on Dec 10, 1922, and that death occurred, on the date stated above, at 5. a. m.

The CAUSE OF DEATH* was as follows:

Chronic Cancer

abdomen (duration) — yrs. 11 mos — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas T Brooke, M. D.

, 19 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sykesville Md (Visitation)	Dec 13 1922
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69970
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

31

D69970
REGISTERED No.

CITY OF BALTIMORE: (No. Municipal Hospital ST., No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Dunston

(a) RESIDENCE No. Unknown ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) S40

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records.
(Address)

15 DEC 12 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 8 1922

17

I HEREBY CERTIFY, That I attended deceased from November 16, 1922, to December 8, 1922.

that I last saw him alive on December 8, 1922,

and that death occurred, on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clin

(Signed) Clyde McNeil, M. D.

12/9/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Dec 13 1922
20 UNDERTAKER	ADDRESS
Edward Ringgold	1463 Carey

Spec.—1-10-21—M&T—1500 Bks.

D69971

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69971

CERTIFICATE OF DEATH.

131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Smith

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
abt 69 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unable to obtain history.

14 Informant Municipal Hospital Records. (Address)

Filed DEC 12 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1922

17 I HEREBY CERTIFY, That I attended deceased from December 5, 1922, to December 9, 1922, that I last saw him alive on December 8, 1922, and that death occurred, on the date stated above, at 6:20 A.M.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

6 mo

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde Mallett M. D.

12/9/, 1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL. Dec 12 1922

20 UNDERTAKER Edward Ringgold — ADDRESS 1463 Carey

D69972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69972

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 20 East St. St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Bowley

(Residence in Baltimore: No. 20 East St, St.; yrs. 72 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col.

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

6-DATE OF BIRTH: ..... 1..... (Month) (Day) (Year)

7-AGE: 48 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Own

9-BIRTHPLACE, (State or Country): Md.

PARENTS:

10-NAME OF FATHER: John Eaton

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Mary Johnson

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Bowley

(Address) 20 East St

15- Filed DEC 12 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec (Month) 10 (Day) 22 (Year) 192...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) Jurors find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. Heart.

(History of Rheumatism) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Chas. Grauley (Coroner) M. D.

Dec 11 1922 (Address) 639 Burns

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn cemetery — DATE OF BURIAL: Dec 12 1922

20-UNDERTAKER: Edward Bryan — ADDRESS 631 Orleans St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69973

CERTIFICATE OF DEATH. 74-001

D69973

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 Leadenhall ST.: 23 WARD)

2-FULL NAME Moses Robb.

(a) RESIDENCE. NO. 920 Leadenhall ST. 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	Col.	Married

5a If married, ~~widowed or divorced~~ WIFE of Carrie Robb.

6 DATE OF BIRTH (month, day, and year) Aug 31 18[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) Stevedore 074

(c) Name of employer Merchants Miners Co

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Jacob Robb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sallie Bardwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Carrie Robb 920 Leadenhall St.

DEC 12 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/8/1922

17 I HEREBY CERTIFY, That I attended deceased from 12/1/1922 to 12/8/1922

that I last saw h alive on 12/8/1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

Acute Interstitial Nephritis

CONTRIBUTORY (Secondary) Mitral Regurgitation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lindsay Whaley M. D.

12/9/1922 (Address) 908 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Dec. 12 1922
20 UNDERTAKER	ADDRESS
J R Brown & Son	108 W. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D69974

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 927 E Biddle St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Jennings

(Residence in Baltimore: No. 927 E. Biddle St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Unknown

(Month) (Day) (Year)

7-AGE. 65 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. Michael Jennings

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Margaret Carey

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Emma Healy

(Address) 927 E Biddle

15 FILED DEC 12 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 11, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart Lesion

Probably Cerebral Embolism

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dyspnea upon exertion for yrs, Rheumatism (Duration) 1 yrs. mos. ds.

(Signed) J. J. Dolan M. D.
(Coroner)

12-12 1922 (Address) 508 E York

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cemetery	Dec. 14 1922
20-UNDERTAKER.	ADDRESS
Henry Hoerth Sons	1301 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

D69975 HEALTH DEPARTMENT—CITY OF BALTIMORE D69975

CERTIFICATE OF DEATH. X 84

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Snell

(a) RESIDENCE NO. Bloomfield, ST., WARD Connecticut
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced (or) WIFE of John T. Snell

6 DATE OF BIRTH (month, day, and year) Aug 10-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	35	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Lawrence Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Matilda Peterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

11 Informant JOHNS HOPKINS HOSPITAL (Address)

15 DEC 12 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11th 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27th, 1922, to Dec 11th, 1922, that I last saw her alive on Dec. 11th, 1922, and that death occurred, on the date stated above, at 9:20 p. m.

The CAUSE OF DEATH* was as follows:

Brain tumor, cerebello-pontine angle tumor

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Mastoiditis, brain abscess

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Oct. 1922

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) F. H. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hartford Conn.

DATE OF BURIAL 12/12 1922

20 UNDERTAKER Philip Henry

ADDRESS 2016 Auburn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Lyons'

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69976

CERTIFICATE OF DEATH.

100-001 D69976

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME Lawrence Lyons.

(a) RESIDENCE NO. 17 Allegheny Av Phila Pa. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Nov 1 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER — Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Margaret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant .....
(Address) .....

15 Filed DEC 12 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1922, to Dec 6, 1922,

that I last saw him alive on Dec 6, 1922,

and that death occurred, on the date stated above, at 2 25 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Signs Symptoms

(Signed) A J Crampton, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	DEC 13 1922 19
20 UNDERTAKER	ADDRESS
Commissioner Health.	

THE MORGAN PRESS 1925

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D69977 HEALTH DEPARTMENT—CITY OF BALTIMORE D69977

CERTIFICATE OF DEATH. 74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 944 Harlem Ave St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Charles Bowe

(Residence in Baltimore: No. 944 Harlem Ave St.; 68 yrs. 7 mos. 7 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced. (Write the word.) widower

6-DATE OF BIRTH. May 4 (Month) (Day) 1854 (Year)

7-AGE. 68 yrs. 7 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. carring Builder
(b) General nature of industry, business, or establishment in which employed (or employer). Bldg

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Hermann Bowe

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Eliz. Loucher

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L. Bowe

(Address) 1010 W. Lanvale

15- Filed DEC 12 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 11 (Month) (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) and Senility

(Duration) .....yrs.....mos.....ds.

(Signed) H. T. Hennighausen M. D. (Coroner.)

Dec 14 1922 (Address) 1221 Eutaw Place

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park DATE OF BURIAL. Dec. 13, 1922

20-UNDERTAKER. John D. Mitchell ADDRESS 1201 W. Fayette St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Czaja

D69978 HEALTH DEPARTMENT—CITY OF BALTIMORE D69978

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 S. Kenwood Ave ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Czaja

(a) RESIDENCE. NO. 107 S. Kenwood Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months | Days | If LESS than 1 day, 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Walter Czaja

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Anna Kluszki

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Walter Czaja 107 S. Kenwood Ave

15 Filed DEC 12 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1922, to Dec 11, 1922, that I last saw h[illegible] alive on Dec 11, 1922, and that death occurred, on the date stated above, at 1230 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
of Seven half months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Oleari, M. D.

12/11, 1922 Address) 2600 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Thomas Lane	Dec 12 1922

20 UNDERTAKER: Stephen J. Stalkowski ADDRESS: 1001 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dymonski

D69979 HEALTH DEPARTMENT—CITY OF BALTIMORE

D69979

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 S. Linwood Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Dymonski

(a) RESIDENCE. No. 1022 S. Linwood Ave ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb 2 1918

7 AGE: Years 4 | Months 10 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Frank Deinowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Stanislawa Stenkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Frank Deinowski (Address) 1022 S Linwood Ave

15 Filed DEC 12 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 11 1922

17 I HEREBY CERTIFY, That I attended deceased from December 11, 1922, to December 11, 1922, that I last saw him alive on December 11, 1922, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronushas, M. D.

12-12-1922 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem — DATE OF BURIAL: Dec 12 1922

20 UNDERTAKER: Stephen J Fiszkowski — ADDRESS: 1003 S Linwood Ave

(Pietrowski)

D69980

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D69980

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 So. Anne St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clemens Pietrowski

(Residence in Baltimore: No. 109 So. Anne St.; yrs., 3 mos. 3 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Unknown (Month) Sep. 8 (Day) 1921 (Year)

7-AGE: 1 yrs. 3 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Kasimir Pietrowski

11-BIRTHPLACE OF FATHER, (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Annie Renik

13-BIRTHPLACE OF MOTHER, (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kasimir Pietrowski

(Address) 109 So. Anne St

15- Filed DEC 12 1922 RUSSELL R. KRAUTER, Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 11 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —

(Duration) ... yrs. ... mos. ... ds.

(Signed) Chas. P. Konzen M. D.

(Coroner)

Dec 12 192 2 (Address) Curtis Bay

OVER

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St. Stanislaus Cem. DATE OF BURIAL. Dec. 13 1922.

20-UNDERTAKER. M. J. Sadowski ADDRESS 705 S. Ann St.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D69981

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D69981

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Alice Lillie

(a) RESIDENCE. No. 3419 Cedar Ave., Hampden WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE: Years 70 | Months | Days | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md.

PARENTS

10 NAME OF FATHER: Sills

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Joseph Sills
(Address) Parkton Md

15 Filed DEC 12 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 11, 1922.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1922, to Dec. 11, 1922

that I last saw h[illegible] alive on Dec 11, 1922

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Pleurisy & Effusion
Cardiac Insufficiency

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Broncho-pneumonia.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Signs.

(Signed) [illegible] M. D.

12/11/1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Cem	Dec. 14 1922

20 UNDERTAKER: Wm. Cook

ADDRESS: 502 E. North Ave

Spec.—1-10-21—M&T—1500 Bks.

D69982 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 D69982

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2611 Sloatfield Ave ST., 20 WARD) 20

2-FULL NAME Eliza Thompson. —

(a) RESIDENCE NO. 2611 Sloatfield Ave ST., ... WARD 20
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 45 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Albert F. Thompson

6 DATE OF BIRTH (month, day, and year) June 30. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Halifax. N. S.

PARENTS

10 NAME OF FATHER Joseph Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sidney. N. S.

12 MAIDEN NAME OF MOTHER Elizabeth Hudson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sidney. N. S.

14 Informant Bessie Scott Cordeal
(Address) 2611 Sloatfield ave. Balto. Md

Daughter

15 Filed DEC 12 1922 19 ..... ROBERT R. KRAUTER, Registrar

Via Penn. R.R. — To Henry Cordeal

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1922

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1922, to Dec 9, 1922, that I last saw her alive on Dec 9, 1922, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ..... yrs. 4 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Asa L Wessels M. D.

(Address) 25-65 Frederick ave 12-10 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn M. Y. DATE OF BURIAL Dec 13 1922

20 UNDERTAKER Tom Cook ADDRESS 601 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69983

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Mehde

(Residence in Baltimore: No. 612 N. Milton ave St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: About 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER: William Weber

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Annie E. Marshall

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Mehde

(Address) 1700 Darley ave

15-

Filed DEC 12 1922 192.. ROBERT J. KRAUTER, Registrar.

Social Service Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec 10th 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Neck of left femur

Duration: yrs. mos. ds.

Fell out of bed at home of son 1700 Darley ave

CONTRIBUTORY (Secondary) Broncho-Pneumonia

Duration: yrs. mos. 2 ds.

(Signed) Thos. H. Horton M. D.

(Coroner)

Dec 11th 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, if Deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St. Matthews. DATE OF BURIAL: Dec 12 1922

20-UNDERTAKER: Wm Cook ADDRESS 502 E. North.

Spec.—1-10-21—M&T 1500 Bks.

D69984

D69984 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 611 W Barre ST., 27 WARD)

2-FULL NAME Susie S. Warrenbeger

(a) RESIDENCE NO. 611 W. Barre ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Warrenbeger

6 DATE OF BIRTH (month, day, and year) Oct 31. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62 yrs.	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓ 037

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm A Trumbo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto -

12 MAIDEN NAME OF MOTHER Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Geo Warrenbeger (Address) 611 W Barre St

15 Filed DEC 12 1922 19 ..... ROBERT P. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1922 to Dec. 11 1922

that I last saw her alive on Dec 11, 1922

and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

Diabetis

(duration) 1 yrs mos 15 ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene

(duration) 15 days yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) M L Friedinger M. D.

12/13/22 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westerne

DATE OF BURIAL Dec 14 1922

20 UNDERTAKER Geo Cools

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69985

CERTIFICATE OF DEATH.

49

D69985

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1327 N. Eden st (St.:) 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert C Ziegler

(a) RESIDENCE. No. 1327 N. Eden St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E Ziegler

6 DATE OF BIRTH (month, day, and year) March 5 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work President Wilcox & Ziegler Corporation

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H Ziegler

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pa

12 MAIDEN NAME OF MOTHER Susan Clemens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot Co Md

14 Informant (Address) Mrs Annie E Ziegler 1327 N. Eden st

15 DEC 12 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 11 1922 to Dec 10 1922 that I last saw h.. alive on Dec 10 1922 and that death occurred, on the date stated above, at 4.07 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas (duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cystitis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1920

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. O Thomas, M. D.

Dec 11 1922 (Address) 1224 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Dec 13th 1922

20 UNDERTAKER George Schulling & Sons

ADDRESS 1126 E Monument st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69986

CERTIFICATE OF DEATH.

D69986

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME Dr. Alexander Rogers Mitchell.

(a) RESIDENCE NO. Mercy Hospital, ST., 4 WARD Monkton, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? 67 yrs. 1 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edith Stockton Conway Mitchell

6 DATE OF BIRTH (month, day, and year) Oct-24-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	67	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physcian

(b) General nature of industry, business, or establishment in which employed (or employer) Medicoine

(c) Name of employer self

9 BIRTHPLACE (city or town) Hereford,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Dr. Fred D. Mitchell

11 BIRTHPLACE OF FATHER (city or town) Hagerstown
(State or country) Maryland

12 MAIDEN NAME OF MOTHER May Eliza Yost

13 BIRTHPLACE OF MOTHER (city or town) Hagerstown
(State or country) Maryland

14 Informant Mrs. Louis Detrick, (daughter)
(Address) 312-Forest Road, Roland Park.

15 Filed DEC 12 1922 ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1922, to Dec 12, 1922,
that I last saw h[illegible] alive on Dec 12, 1922,
and that death occurred, on the date stated above, at 10 45 a.m.
The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sugar Urine & Blood

(Signed) [illegible] M. D.

, 19 (Address) Emerg Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
GREENCOE, BALTO. CO. MD.	Dec-12-22'
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 103 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69987

D69987

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2926 E. Madison ST., 7 WARD)

2-FULL NAME Richard E. Pittinger

(a) RESIDENCE NO. 2926 E. Madison ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 20-1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Marion J. Pittinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Rathgeber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Marion J. Pittinger
(Address) 2926 E. Madison St

15 Filed , 19 Robert F. Haffner, Registrar
Burial Permit Clerk.

DEC 12 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922 to Dec 10, 1922

that I last saw him alive on Dec 10, 1922

and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

over

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. Zell Pennington M. D.

19 (Address) 800 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Dec. 13 1922
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69988

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69988

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 3330 Chestnut ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Sullivan

(Residence in Baltimore: No. 3330 Chestnut ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Unknown (Month) ..... (Day) 1 (Year)

7-AGE, About 70 yrs. mos. ds.

If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) 087

9-BIRTHPLACE, (State or Country). Balto Co

PARENTS.

10-NAME OF FATHER Maylon Justie

11-BIRTHPLACE OF FATHER (State or Country). md

12-MAIDEN NAME OF MOTHER Nancy Shipley

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Phillip Justie

(Address) 3330 Chestnut Ave

15-

Robert P. Harrison, Registrar.

Filed ....., 191.....

DEC 12 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 11, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained at said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Morrison M. D. (Coroner)

Dec 11, 1922 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden

DATE OF BURIAL, Dec 13 1922

20-UNDERTAKER Chenowith Son

ADDRESS Chestnut Ave

WRITE PLAINLY, WITH UNFADING INK.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69989

CERTIFICATE OF DEATH.

D69989

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

2-FULL NAME Baby George Mack

(a) RESIDENCE NO. University Hospital ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 9, 1922

7 AGE — Years — Months — Days — If LESS than 1 day, 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Mack

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sylvia Kelly

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 DEC 12 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 9, 1922, to Dec 10, 1922, that I last saw h/m alive on Dec 10, 1922, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Prematurity
(30 wks foetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Nephritic Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical Findings

(Signed) T. Norwood Wilson M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

per Wm. E. WOODALL

JOHNS HOPKINS HOSPITAL

DEC 1 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69990

CERTIFICATE OF DEATH.

161-001

D69990

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., 4 WARD)

2-FULL NAME Baby William Mack

(a) RESIDENCE NO. University Hospital ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1922

7 AGE	Years	Months	Days	If LESS than 1 day 4 hrs. or 25 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Mack

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sylvia Kelly

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant (Address) Hospital Records
Robert P. Harrison.

15 Filed ..... 19 .....
EC 2 1922 Burial Permit Issued Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 9 1922 to Dec 10 1922
that I last saw h/ Malive on Dec 10 1922
and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Premature birth
(30 hrs Postem)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Maternal Syphilitic Toxemia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? NO Date of .....

Was there an autopsy? NO

What test confirmed diagnosis? Clinical Findings

(Signed) L. Norwood Wilson M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner of Health,
By Wm. E. WOODALL
DEC 1-1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69991

D69991

CERTIFICATE OF DEATH.

44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers of America Hospital ST.; WARD)

2-FULL NAME Charles Lucke

(a) RESIDENCE. NO. 27 S. Curley ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Lucke

6 DATE OF BIRTH (month, day, and year) June 1858

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
64	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Charles H. Schubert

(Address) 27 S. Curley St.

15 Filed DEC 12 1922 19 Robert P. Carlson, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1922, to Dec 10, 1922, that I last saw him alive on Dec 10, 1922, and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. mon. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray diagnosis

(Signed) Albert J. Conrey, M. D.

, 19 (Address) Vol. of America Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Oak Lawn Cem. — Dec. 13 1922

20 UNDERTAKER — ADDRESS

H. Vander Sons — 1710 Eutaw St

MARGIN RESERVED

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item & information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69992 D69992

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 Fleet ST., 3 WARD)

2-FULL NAME William Fickle

(a) RESIDENCE NO. 1570 Fleet ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Fickle

6 DATE OF BIRTH (month, day, and year) March 25, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bremen (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Emma Taylor (Address) 527 S. Ballard

15 Filed ..... 19 ..... Registrar

DEC 12 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 9th, 1922, to Dec 10th, 1922, that I last saw h[illegible] alive on Dec 10th, 1922, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Insufficiency

20 - (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Emmanuel Strauss, M. D.

Dec 12 1922 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Dec 13 1922

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Eastern Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69993 HEALTH DEPARTMENT—CITY OF BALTIMORE D69993

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 W Conway ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Cole

(a) RESIDENCE. No. 532 W. Conway St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md Town

12 MAIDEN NAME OF MOTHER Ann A Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Town

14 Informant (Address) Mrs L Cole 532 N Conway

15 Filed ....., 19.... Robert P. Harrison, Registrar

EC 12 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1922

17 I HEREBY CERTIFY, That I attended deceased from

Oct 20, 1922, to Dec 7, 1922,

that I last saw h alive on Dec 8, 1922,

and that death occurred, on the date stated above, at 11-45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Tuttle Dudley, M. D.

Dec 9, 1922 (Address) 2926 Gwynn Oak Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Dec 12 1922

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be properly classified. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Chase) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69994 D69994

CERTIFICATE OF DEATH.

JH-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 N Amity ST.: 18 WARD)

2-FULL NAME Jennie C Chase

(a) RESIDENCE. NO. 22 N Amity ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col'd

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE: Years 49 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Ella Blockton

(Address) 22 N Amity

15 Filed ..., 19... E. CARPENTER, Registrar

DEC 12 1922

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 20 1922, to Dec 11, 1922,

that I last saw h... alive on Dec 11, 1922,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Dec 13, 1922 (Address) 9 Bay n Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Dec 14 1922

20 UNDERTAKER: Daniel Easton & Co

ADDRESS 916

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item & information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-23—M&T—1500 Bks.

(Bradshaw) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69995

D69995

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE: (NO. ..... ST., 11 WARD)

2-FULL NAME Henrietta Brodobur

(a) RESIDENCE NO. 1302 McCulloh ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE Years 52 Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Do

11 BIRTHPLACE OF FATHER (city or town) (State or country) .....

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Daniel Earlon

(Address) 916 Pa ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1922, to Dec 10, 1922

that I last saw h alive on Dec 9, 1922 3:30 a.m.

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Primary)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) N. F. Edmunds, M. D.

12/10/22 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Dec 13 1922

ADDRESS 916 Pa ave

20 UNDERTAKER Daniel Earlon

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates

DEC 13 1922

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69996 D69996

CERTIFICATE OF DEATH.

No 38

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital ST., ... WARD)

2-FULL NAME Anna Curtis

(a) RESIDENCE NO. Bay View ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant ..... (Address) Bay View Md.

15 Dec 12 1922 Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-9-1922

17

I HEREBY CERTIFY, That I attended deceased from 11-27, 1922 to 12-9, 1922

that I last saw h[illegible] alive on 12-9, 1922

and that death occurred, on the date stated above, at 2:15 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Probably Cystic Pulmonary Edema

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clyde McNeal M. D.

Dec 13 1922 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Dec 13 1922

20 UNDERTAKER David Eaton — ADDRESS 916 Eager

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 12 1922

Burial Permit Clerk.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

DEC 12 1922

D69997 HEALTH DEPARTMENT—CITY OF BALTIMORE D69997

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH: City of BALTIMORE: (No. On a street car at Fort Ave. & Hull St. St., 24 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Bernard H. Prenger. 67 yrs. 1 mos. 21 ds.

(Residence in Baltimore: No. 1310 William St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. October 19th 1855. (Month) (Day) (Year)

7-AGE. 67 yrs. 1 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman, stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R. Co.

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Gerhard Prenger.

11-BIRTHPLACE OF FATHER. (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Elizabeth Rohy.

13-BIRTHPLACE OF MOTHER. (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Prenger. (wife)

(Address) 1310 William St.

15- Robert P. Harrison, Registrar.

Filed ..... 192 ..... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Dec 12th 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	Dec. 13 1922
20-UNDERTAKER. Margaret A. Flynn	ADDRESS 1432 Light St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69998

D69998

CERTIFICATE OF DEATH.

52

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 Richmond ST. 11 WARD)

2-FULL NAME Anne Kieran Hanrathy

(a) RESIDENCE NO. 220 Richmond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 52 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Hanrathy

6 DATE OF BIRTH (month, day, and year) June 29, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	11	

8 OCCUPATION OF DECEASED Market (Store) Seller.

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Matthew Kieran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss May Hanrathy (Address) 220 Richmond St.

15 Filed ..., 19 ... Registrar

Burial Permit Clerk

DEC 12 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17

I HEREBY CERTIFY, That I attended deceased from ..., 1919, to Dec 10, 1922,

that I last saw her alive on 12/10, 1922,

and that death occurred, on the date stated above, at six P m.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans with severe contractures arms & legs

(duration) 3 yrs. ( ) mos ds.

CONTRIBUTORY (Secondary) Pneumonia (hypostatic)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R.G. Fechtig, M. D.

, 19 (Address) 1011 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL 12/13 1922

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Brunnett) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69999

D69999

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1145 N. Milton ave. WARD) 9

2-FULL NAME Mary M. Brunnett

(a) RESIDENCE NO. 1145 N. Milton ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of late John Brunnett

6 DATE OF BIRTH (month, day, and year) Sept 5 1844

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	78	3	4	~~If LESS than 1 day ... hrs. or ... min.~~

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer) 037
(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER J. Beers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER M. Beers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss K. Brunnett
(Address) 1145 N. Milton ave

15 Filed ..... 19 ..... Registrar Robert F. Duffield

DEC 12 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1922, to Dec 8, 1922,
that I last saw h... alive on Dec ..., 19...,
and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Contributory Pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) ....., M. D.
....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec 13 1922.
20 UNDERTAKER George J. Rutt	ADDRESS 1735 Harford Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70000 HEALTH DEPARTMENT—CITY OF BALTIMORE D70000

CERTIFICATE OF DEATH. 188-003 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christopher Myers

(Residence in Baltimore: No. 2220 Christian St.; yrs., 1 mos., 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-(Single, Married, Widowed, Divorced, Write the word.) Married

6-DATE OF BIRTH. Aug (Month) 2 (Day) 1845 (Year)

7-AGE. 77 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Labr
(b) General nature of industry, business, or establishment in which employed (or employer). Dry

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Philip Myers

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Hannah Brackenbush

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Myers

(Address) 2220 Christian

15- Robert P. Harrison,

Filed ..... 192..... Burial Permit Clerk. Registrar.

DEC 12 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 9 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture base of skull
Fracture Hip Contusion
Accident while walking on Street (Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) James M. Teute M. D. (Coroner.)

Dec 10 1922 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death 4 yrs. mos. 4 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Fredericksburg & Smallwood Ry

Former or usual residence 2220 Christian

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, 12/13 1922

20-UNDERTAKER, Robert Brookesson

ADDRESS CALHOUN HOLLINS ST

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70001

CERTIFICATE OF DEATH.

D70001

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 N. Payson St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Jane Walker

(Residence in Baltimore: No. 105 N. Payson St.: 15 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6-DATE OF BIRTH: August 1st, 1860 (Month) (Day) (Year)

7-AGE: 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: (on)
(b) General nature of industry, business, or establishment in which employed (or employer): Housework

9-BIRTHPLACE, (State or Country): W. Va.

PARENTS.

10-NAME OF FATHER: Casper Ulbrick

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Margaret Ulbrick

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Cowing

(Address) 105 N. Payson

15- Baltimore, 1922 Robert P. Harrison, Registrar.

Deputy Clerk.

DEC 21922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 10, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1922, to Dec. 1922, that I saw her alive on Dec 9 1922, and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. B. Mann M. D.

12-11-, 1922 (Address) 801 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, 12-13-, 1922

20-UNDERTAKER Wm Cook — ADDRESS 502 E North.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70002

D70002

CERTIFICATE OF DEATH.

44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 24 WARD)

2-FULL NAME William Craft.

(a) RESIDENCE. NO. 1124 Battery Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cecelia Craft.

6 DATE OF BIRTH (month, day, and year) March 5 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Chas. Craft.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Anna Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Cecelia Craft

(Address) 1124 Battery Ave

15 Filed [illegible] 19 Robert P. Harrison, Registrar

Daniel Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12, 1922.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1922, to Dec. 12, 1922, that I last saw h. alive on Dec. 12, 19 xx, and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

Gastric carcinoma.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 12/10/22.

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation - autopsy.

(Signed) Dr Willis Compton, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 12/15 19[illegible]

20 UNDERTAKER UP Co 6

ADDRESS 502 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVED FOR [illegible]

DEC 14 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70003

CERTIFICATE OF DEATH.

101-001 D70003

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6211 Wilday Av Gorsuch ST., 27 WARD)

2-FULL NAME Katherine E. Ammenheuser

(a) RESIDENCE No. 6211 Wilday Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John M. Ammenheuser

6 DATE OF BIRTH (month, day, and year): Sept 17 1849

7 AGE: Years 73; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Peter Koch.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John M. Ammenheuser

(Address): 6211 Wilday Ave

DEC 12 1922 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-11 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 2. 1922 to Dec. 11 1922, that I last saw h alive on Dec. 11 1922, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. O'Hara M. D.

12/12 1922 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem. DATE OF BURIAL: Dec 14 1922

20 UNDERTAKER: Lowe and Koontz ADDRESS: York & Hoch

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Mc Quirk

Spec.—1-10-21—M&T—1500 Bks.

D70004

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70004

CERTIFICATE OF DEATH.

X 179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry McQuirk

(a) RESIDENCE NO. Principio Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs McQuirk

6 DATE OF BIRTH (month, day, and year) Nov. 24-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	—	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ironworker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Record Md. General Hospital

15 FILED DEC 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 3 1922 to Dec 12 1922

that I last saw him alive on Dec 12 1922

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate Gland

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Chronic Myocarditis

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Dec 7-22

Was there an autopsy? Yes

What test confirmed diagnosis? Clinically

(Signed) James H. Wilkinson M. D.

19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Perryville Md.

DATE OF BURIAL 12/13 1922

UNDERTAKER Chas H. Evans & Son

ADDRESS 1181 W. Royalton

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70005

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70005

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 530 S. Belnord Ave. (Ward) 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Meyers.

(a) RESIDENCE NO. 530 S. Belnord Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. F. Meyers

6 DATE OF BIRTH (month, day, and year) Aug 8th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany. Lutz

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John P. Meyers 2824 Dillon St.

15 Filed DEC 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to Dec 9, 1922,

that I last saw h alive on Dec 9, 1922,

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse nephritis

(duration) yrs. 7 mos 9 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No one

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) [illegible] M. D.

1410 1922 (Address) 1623 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL Dec 14 1922

20 UNDERTAKER John A Moran — ADDRESS 3000 E Balto st.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cutledge

Spec.—1-10-22 D70006

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 7K-001 D70006

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3909 Bonner Rd. ST. Forest Pk WARD)

2-FULL NAME Elizabeth Wynne Johnson

(a) RESIDENCE NO. 3909 Bonner Rd. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Johnson

6 DATE OF BIRTH (month, day, and year) June 11" 1836

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
86	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Liverpool
(State or country) England

PARENTS

10 NAME OF FATHER Mr. Rodgers

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) England

14 Informant Mr. Eugene D. Johnson
(Address) 3909 Bonner Road

15 FILED DEC 13 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11" 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 14th, 19..., to Dec 11th, 1922, that I last saw h[er] alive on Dec 11th, 1922 and that death occurred, on the date stated above, at 1.05 P.m.

The CAUSE OF DEATH* was as follows:

Asthma Edematous.
Chronic Interstitial Nephritis

(duration) 10 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Autopsy

(Signed) Helen F. Freeman, M. D.

Dec. 11 1922 (Address) 1227 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Dec 13" 22
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bolton St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70007 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D70007

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Edgewood St. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes E. Blair

(a) RESIDENCE No. 607 Edgewood St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James T. Blair

6 DATE OF BIRTH (month, day, and year) Dec. 25" 1853

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
69	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER James B. Pines

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Kryle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James B. Blair (Address) 607 Edgewood St.

15 Filed DEC 13 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11" 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 10 19 22 to Dec 11" 19 22

that I last saw h[illegible] alive on Dec 11- 19 22

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis

Mitral Regurgitation

(duration) 1 yrs. \ mos \ ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) \ yrs. \ mos. 5 ds.

18 Where was disease contracted if not at place of death? 2202 Lynbrook Rd

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Physical Exam.

(Signed) Thomas J. Talbott, M. D.

12/13 19 22 (Address) Marlborough Apt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL All Saints Cem St Mary's Co Maryland — DATE OF BURIAL Dec 14 1922

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 N Balto

Spec.—1-10-21—M&T—1500 Bks.

D70008 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D70008

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3103 N. Calvert ST. 12 WARD)

2-FULL NAME Levi E. Hasson

(a) RESIDENCE NO. 3103 N. Calvert ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2/19/1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ret. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) — 086

(c) Name of employer —

9 BIRTHPLACE (city or town) Cecil Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel

11 BIRTHPLACE OF FATHER (city or town) — (State or country) Md

12 MAIDEN NAME OF MOTHER Elezabeth Alexander

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) Md.

14 Informant Adaline Hasson (Address) 3103 N. Calvert St

15 Filed DEC 13 1920 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1920

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1920 to Dec 12 1920

that I last saw him alive on Nov. 20 1920

and that death occurred, on the date stated above, at 12:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 5 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robert Crutchfield M. D.

Dec 13 1920 (Address) 711 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Colora, Cecil Co, Md. DATE OF BURIAL Dec 13, 1920

20 UNDERTAKER Wm. Cook ADDRESS 502 E. North ave.

Dr 711 W Lanvale St
via P RR C/o Mrs Adeline Hasson

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70009

D70009

CERTIFICATE OF DEATH.

90 ✓

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 428 W. Pine ST.; 17 WARD)

2-FULL NAME John A. Holmes

(a) RESIDENCE. NO. 428 N. Pine ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah B. Holmes

6 DATE OF BIRTH (month, day, and year) Dec 11 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lexington, Va.

PARENTS

10 NAME OF FATHER Matthew J. Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lexington, Va

12 MAIDEN NAME OF MOTHER Nellie Harper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lexington, Va

14 Informant Sarah B. Holmes (Address) 428 N. Pine St.

15 Filed . 19 ROBERT F. KRAUSER Registrar

DEC 13 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/10/ 1922

17 I HEREBY CERTIFY, That I attended deceased from 11/24/ 1922 to 12/10/ 1922

that I last saw him alive on 12/9/ 1922

and that death occurred, on the date stated above, at 3.25 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. Hawkins, M. D.

(Address) 1216 E. Pt. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 12/13/ 1922

20 UNDERTAKER Samuel Hemsley — ADDRESS 578 Mildale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Jr. H. Schoberg.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70010 57 D70010

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, No. 340 St Joseph Hospital ST., 24 WARD)

2-FULL NAME Jos. H. Schoberg.

(a) RESIDENCE NO. 1225 Battery Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ferdinandena Hawke

6 DATE OF BIRTH (month, day, and year) April 9, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	57	8	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) 034
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Herman Schoberg

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Theresa Brokamp

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Ferdinandena Schoberg
(Address) 1225 Battery Ave

15 DEC 13 1922 ROBERT R. KRAUTER, Registrar
Filed Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 7 1922 to Dec 11 1922

that I last saw him alive on Dec 11 1922 and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Insuff.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic analysis

(Signed) Jos Scheurich, M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a a Co

DATE OF BURIAL 12-15 1922

20 UNDERTAKER Ehrlich Harle

ADDRESS 115 E Hoff St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70011

CERTIFICATE OF DEATH.

X 13 113

D70011

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2412 Callow Ave. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Eugene Fear

(a) RESIDENCE. No. 2412-Callow-Ave. ST., 13 WARD. MorrisPlains, N.J.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 27 ds. How long in U. S., if of foreign birth? 0 yrs. 2 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) Sept-13-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Morris Town New Jersey

PARENTS

10 NAME OF FATHER James W. Fear

11 BIRTHPLACE OF FATHER (city or town) (State or country): HollandPattent New York

12 MAIDEN NAME OF MOTHER Maud Douglas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greys New York

14 Informant James W. Fear, (father)
(Address) Morris Plains N.J.

15 DEC 13 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1922, to Dec. 12, 1922, that I last saw him alive on Dec. 12, 1922, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(duration) 0 yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Moris Town N. J.

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? —

(Signed) Benjamin Tappan, M. D.

12/13, 1922 (Address) 1102 N. Charles St, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Little Falls, Herkimer Co. N.Y.	Dec-13-22

20 UNDERTAKER	ADDRESS
STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	103 W. NORTH AVE.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in making out the CERTIFICATE. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70012

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

8

90

D70012

Registered No. C.....

City of BALTIMORE: (No. 2306 E Federal St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mary A. Morris

(Residence in Baltimore: No. 2306 E Federal St.; yrs. 70 mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

6-DATE OF BIRTH. Sept 23 (Month) (Day) 1850 (Year)

7-AGE. 92 yrs. 2 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Stone
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Pa

PARENTS.

10-NAME OF FATHER. Jno W. Schlosser

11-BIRTHPLACE OF FATHER, (State or Country). Pa

12-MAIDEN NAME OF MOTHER. Eliza Coates

13-BIRTHPLACE OF MOTHER, (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche E. Dorsey

(Address) 2306 E Federal

15-

Filed DEC 13 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 12 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

over

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Collier M. D. (Coroner.)

12-12-192 2 (Address) 306 E Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore

DATE OF BURIAL. Dec 14 192 2

20-UNDERTAKER. Zirkler & Zirkler

ADDRESS 1739 Eager

Remarks .....

Valvular Disease of Heart

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70013

CERTIFICATE OF DEATH.

101-001

D70013

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 N. Potomac ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia L. Barnes

(a) RESIDENCE NO. 36 N. Potoman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Barnes

6 DATE OF BIRTH (month, day, and year) March 13-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Herman Dopman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Charles G. Barnes (Address) 36 N. Potoman St.

15 DEC 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1922, to Dec. 11, 1922, that I last saw h 22 alive on Dec 11, 1922, and that death occurred, on the date stated above, at 12 50 A. m.

The CAUSE OF DEATH* was as follows:

Lobarpneumania

(duration) ..... yrs. ..... mos 3 ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Robert L Green M. D.

12-11-1922 (Address) 120 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn

DATE OF BURIAL Dec 14 1922

20 UNDERTAKER Zickler & Zickler

ADDRESS 1739 Eager

Spec.—8-24-14—M. & T.—2000 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70014
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

5 129

D70014
REGISTERED No. C

CITY OF BALTIMORE: (No. 205 N. Eden ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Jane Barnett

(Residence in Baltimore: No. 205 N. Eden St St.; 40 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, unknown (Month), 1 (Day), — (Year)

7-AGE, 58 apprx yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Cambridge Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Caroline Bazil

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Barnett

(Address) 205 N Eden St

15- Filed DEC 13 1922 ROBERT R. KRAUTER, Burial Permit Clerk. 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 10 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1922, to Dec 10 1922, that I saw her alive on Dec 9 1922, and that death occurred, on the date stated above, at 10 20 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

12/12, 1922 (Address) 1524 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery

DATE OF BURIAL. Dec 13, 1922

20-UNDERTAKER Mrs Robert A Elliott

ADDRESS 1715 Madison Ave

Remarks. Acute L. angustus – (Not Dip.)
Cultura negativa. Potatorum (?)
" " (Mc Callum)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis.*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis.*	*Septicemia.*
Convulsions,	*Erysipelas,*	*Peritonitis.*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D70015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70015

CERTIFICATE OF DEATH.

5 90

Registered No. C .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 128 East St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Kahler or Caylor or something near that

(Residence in Baltimore: No. 128 East St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1... (Year)

7-AGE. 63 years by Margaret James — yrs. ..... mos. ..... ds. — If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Sailor
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie James

(Address) 128 East St.

15-

FILED DEC 13 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH. Dec (Month) 11 (Day) 192 7 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paral. dis. heart

..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) W. J. Foley M. D.
(Coroner.)

Dec 13 192 2 (Address) 1 E Saratoga

*State the Disease causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	12/14/22

20-UNDERTAKER.	ADDRESS
R. E. Parham	220 N Hanover

D70016 HEALTH DEPARTMENT—CITY OF BALTIMORE D70016

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hosp. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Emma Aileen Gillen

(Residence in Baltimore: No. 2540 Mosher St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 22 (Day) 1922 (Year)

7-AGE, 7 yrs. 6 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, John L. Gillen

11-BIRTHPLACE OF FATHER, (State or Country), Balto Co Md

12-MAIDEN NAME OF MOTHER, Hester Corrigan

13-BIRTHPLACE OF MOTHER, (State or Country), Cumberland Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J L Gillen

(Address) 2540 Mosher St

15-

FILED DEC 13 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 10 (Month) (Day) 192.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Edema of Glottis
6 days
(Hyperplasia of adenoid tissue) (Duration) yrs. mos. ds.

~~CONTRIBUTORY~~ (Secondary) Autopsy at Hopkins
(Duration) yrs. mos. ds.

(Signed) H. H. Nalle M. D.
(Coroner)

12-11 192.. (Address) 508 E North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Peters Cemetery DATE OF BURIAL, 12-13-1922

20-UNDERTAKER, H C Brauning Son ADDRESS 517 N Eutaw St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70017

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70017

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 Clinton ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A Dreshack

(a) RESIDENCE. NO. 612 Clinton ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of :

6 DATE OF BIRTH (month, day, and year) Oct 23. 1888

7 AGE: Years 34; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst Office Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Anna C. Dreshack (Address) 612 Clinton ave

15 Filed DEC 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 7 1922 to Dec 11 1922, that I last saw him alive on Dec 11 1922, and that death occurred, on the date stated above, at 6 00 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of x

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Wm Williams M. D.

, 19 (Address) 601 Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL 12-14. 1922

20 UNDERTAKER: H C Manning Son

ADDRESS 517 N Schroeder st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70018

CERTIFICATE OF DEATH.

D70018

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6th Ave & Towson ST. Bklyn WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Katherine Jackson

(a) RESIDENCE NO. 6th ave & Towson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Jackson

6 DATE OF BIRTH (month, day, and year) July 14, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Jno. Neidline

11 BIRTHPLACE OF FATHER (city or town) — (State or country) Md

12 MAIDEN NAME OF MOTHER Laura Nuff

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) Germany

14 Informant (Husband: Walter Jackson)
(Address) 6th ave & Towson and St

15 Filed DEC 13 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1922, to Dec 12, 1922, that I last saw h[illegible] alive on Dec 11, 1922, and that death occurred, on the date stated above, at 4 hrs m.

The CAUSE OF DEATH* was as follows:

Chron. Gastro-Enteritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. Victor Dill M. D.

12/13 1922 (Address) 1433 Wmsburg Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 12/15/ 1922

20 UNDERTAKER Wm. Cook, 502 E. North ave — ADDRESS

TION is very important. See instructions on back of certificates.

Spec.-1-10-21 M&T 1500 Blks.

D70019

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70019

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 N. Fremont ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Handley.

(a) RESIDENCE NO. 111 N. Fremont ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chas E. Handley

6 DATE OF BIRTH (month, day, and year) Mar- 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	83	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Balto. Knox

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant .....
(Address) 111 N. Fremont Ave

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
DEC 13 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 19 22, to Dec 12, 19 22,

that I last saw h... alive on Dec 9, 19 22,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ....., M. D.

, 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Dec 14 19 22

ADDRESS .....

20 UNDERTAKER Wm Cook.
501 E Mott

MARGIN RESERVED FOR RECORD. Entry No. .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70020

HEALTH DEPARTMENT--CITY OF BALTIMORE

D70020

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 841 N. Fremont Ave. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry F. Getter

(Residence in Baltimore: No. 844 N. Fremont Ave. St.; yrs. 69 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	widower

6-DATE OF BIRTH. March 3, 1853 (Month) (Day) (Year)

7-AGE. 69 yrs. 9 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): R. R. 015

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Cornelius Getter

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Eliz. Harrison

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Marion Dunlap

(Address) 841 N. Fremont Ave

Filed DEC 13 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) ....yrs. ....mos. 1 ....ds.

CONTRIBUTORY (Secondary) no history

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Dec. 12 1922 (Address) 232 Eutaw Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	12/14/22
20-UNDERTAKER.	ADDRESS.
Wm Eddie Walker	723 N Lafayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002 D70021

REGISTERED NO.

D70021

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Holbrook ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Coffey

(a) RESIDENCE. NO. 1502 Holbrook ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR RECORDING DATA—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70022

CERTIFICATE OF DEATH.

38 D70022

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Lins

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Joiner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Municipal Hospital Records.
(Address)

15 DEC 13 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 11 1922

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1921, to December 11 1922.

that I last saw h in alive on December 11, 1922.

and that death occurred, on the date stated above, at 9:00 P.M.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Aortic aneurysm

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde M. Reed, M. D.

12/12/ 1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Church Cem (Baltimore)

DATE OF BURIAL Dec 14 1922

20 UNDERTAKER John Ullrich

ADDRESS 2008 Orleans

MARGIN RESERVED FOR RECORD. EARS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EARS
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact settlement of OCCUPATION is very important. See instructions on back of certificates.

Time of burial extended to 2 P.M. 12, 15, 22

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70023 Asst Cor. Ptg

REGISTERED NO. D70023

D70023
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 W. Pratt ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lemuel O. Stubbins

(a) RESIDENCE. NO. 125 W Pratt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 30/1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm D. Stubbins
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.
12 MAIDEN NAME OF MOTHER Matilda E. Brady
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Wm D Stubbins 125 W Pratt

15 Filed DEC 13 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 13, 1922, that I last saw h alive on Dec 13, 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What (est confirmed diagnosis) Pneumonia

(Signed) M C Campbell M.D.

Dec 13 1922 (Address) 1444 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	12/15 1922
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D70024 — 90 — D70024

REGISTERED NO. C

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

D70024

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1500 N. Charles ST.: 12 WARD)

2-FULL NAME Reuben Miner Ridgely

(Residence in Baltimore: No. 1500 N. Charles St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6 DATE OF BIRTH Sept 27, 1867 (Month) (Day) (Year)

7 AGE 55 yrs. 2 mos. 21 ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer) 042

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER Reuben Ridgely

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Camilla McKean

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Reuben M. Ridgely
(Address) The Walbert

15 FILED DEC 13 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 13, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1922, to Nov 12 1922,
that I saw h[illegible] alive on Nov 1 1922 at 8:20 a.m.
and that death occurred, on the date stated above, at 8:20 a.m.
The CAUSE OF DEATH* was as follows:

Hypertrophied Heart & Weakened Valvular Action

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY) Acute Indigestion (Duration) yrs. mos. 8 ds.

(Signed) Wm Grant M. D.
Nov 13, 1922 (Address) 1100 Park Heights Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.

Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 12-15 1922

20 UNDERTAKER Perkins Jenkins Co — ADDRESS [illegible]

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X71-001

D70025

REGISTERED NO. D70025

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH D70025 Johns Hopkins Hospital

CITY OF BALTIMORE: (No. 7 ST., WARD)

2-FULL NAME Barclay Ober

(a) RESIDENCE NO. Lutherville Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word)
Male	White	Single

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Nov 12 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Gustavus Ober Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md.

12 MAIDEN NAME OF MOTHER B. Barclay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs Barclay Ober (Address) Lutherville Md

15 Filed DEC 13 1922 ROBERT R. KRAUTER, Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 12 1922 to Dec 13 1922, that I last saw him alive on Dec 12 1922, and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Meningitis (Streptococcus)

(duration) — yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) Convulsions (duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? Lutherville, Md

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Lumbar puncture & exam. of spinal fluid.

(Signed) James P. Hamburger M. D.

Dec 13, 1922 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL Dec 14 1922

20 UNDERTAKER Henry Heuisler & Son Co ADDRESS Cor. Eutaw & Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70026

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70026

CERTIFICATE OF DEATH.

91-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1205 St Paul St.: 11 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wallace Spence

(a) RESIDENCE. No. 1205 St Paul St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced (write the word)~~: married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~: Harriet Wade Spence

6 DATE OF BIRTH (month, day, and year): April 6th 1850

7 AGE — Years: 72 — Months: 8 — Days: 6 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Financier

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

886

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: William W Spence

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Mary A. C. Winkley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Norfolk Virginia

14 Informant: Mrs W. W. Spence
(Address) 1205 St Paul St

15 Filed ..., 19... [illegible] Registrar

DEC 13 1922

Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 12 Am, 1922, to Dec 12 Pm, 1922, that I last saw him alive on Dec 12. 12:30 Pm, 19..., and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Rupture thoracic Aneurism

not known (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

not known (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no What test confirmed diagnosis? Physical Examination

(Signed) H Warren Buckler, M. D.

, 19 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	12-14 1922
20 UNDERTAKER: Henry J Eastham & Sons Co	ADDRESS: Mt Auburn & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70027

D70027

CERTIFICATE OF DEATH.

105-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

2-FULL NAME Benjamin Parker

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
46	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Municipal Hospital Records.

(Address)

15 ..... 19 ..... Registrar

DEC 13 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 19 22

17 I HEREBY CERTIFY, That I attended deceased from December 8, 19 22, to December 9, 19 22, that I last saw him alive on December 9, 19 22, and that death occurred, on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.

12/11/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

ADDRESS DEC 13 1922

20 UNDERTAKER

Commissioner Health.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS SHOULD SIGN CERTIFICATES. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70028

D70028

CERTIFICATE OF DEATH.

118-062

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 McHenry ST.: 19 WARD)

2-FULL NAME Wilhelmina B. Wattenschaft

(a) RESIDENCE. No. 1720 McHenry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of August Wattenschaft

6 DATE OF BIRTH (month, day, and year) Dec. 20.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gottlieb Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Agnes M. Fitzinger

(Address) 1720 McHenry St.

15 DEC 16 1922, 19 Robert F. Carrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1922, to Dec 11, 1922, that I last saw h alive on Dec 11, 1922, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia 12 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction 36 hrs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly M. D.

12/12, 1922 (Address) 1027 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	12/14/ 19

20 UNDERTAKER Wm. Cook ADDRESS 507 E. North

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D70029

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70029

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1817 Linden Ave ST. WARD)

REGISTERED No. C 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hitchcock Buel

(Residence in Baltimore: No. 1817 Linden Ave St.; yrs., 7 mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, May (Month) 14 (Day), 1863 (Year)

7-AGE, 59 yrs. 6 mos. 28 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Vermont

PARENTS.

10-NAME OF FATHER: Rev David H. Buel

11-BIRTHPLACE OF FATHER (State or Country): Troy N. Y.

12-MAIDEN NAME OF MOTHER: Mary Atkinson

13-BIRTHPLACE OF MOTHER (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas Atkinson
(Address) Elmwood Apartments

15- Robert P. Harrison,
Dated DEC 13 1922, 191...
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12, (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) J. F. Hennessy M. D.
(Coroner.)
Dec 13 1922 (Address) 2007 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount — DATE OF BURIAL: Dec 17, 1922

20-UNDERTAKER: Williamson — ADDRESS: 503 E North Ave

Dr Hennessy

WRITE PLAINLY, WITH UNFADING INK.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70030 D70030

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Somerset ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Chambers

(Residence in Baltimore: No. 502 Somerset St St.; 27 yrs. mos. ds.)

WRITE PLAINLY, WITH INK.

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If unknown, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan (Month) 18 (Day), 1891 (Year)

7-AGE, 31 yrs. 10 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work [redacted]
(b) General nature of industry, business, or establishment in which employed (or employer) Employed in Woolen factory

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Geo Scott

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Sarah Chambers

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Scott Mother

(Address) 502 Somerset St

15-

Filed Nov 29 1922 Robert P. Harrison, Registrar.

DEC 13 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 12 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1922 to Dec 12 1922 that I saw h er alive on Dec 11 1922 and that death occurred, on the date stated above, at 02 45 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

Mitral Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) D J Young M. D.

12/14, 1922 (Address) 1929 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, To Chester Md. DATE OF BURIAL, Dec 14 1922

20-UNDERTAKER Mrs J. G. Locke ADDRESS 1302 Jeffers

Spec.—1-10-21—M&T—1500 Bks.

D70031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70031

CERTIFICATE OF DEATH.

160

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3108 Ellerslie ST., 9 WARD)

2-FULL NAME Philip Schisler Jr.

(a) RESIDENCE NO. 3108 Ellerslie ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 13 ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 1st 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Philip Schisler

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mabel Baylor

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant M. Philip Schisler
(Address) 3108 Ellerslie Ave.

15 Filed DEC 13 1922, 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 13, 1922,

that I last saw him alive on Dec 12, 1922

and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus Exposure

(duration) ..... yrs. ..... mos 12 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Clinical —

(Signed) John S. Fenby, M. D.

12/13, 1922 (Address) 3522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Dec. 14 1922
20 UNDERTAKER	ADDRESS
Henry Worch Son	1301 E Eager

MARRIAGE CERTIFICATE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in giving information. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

124 D70032

D70032

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Mercy Hospital WARD) 10

2-FULL NAME Elizabeth Reed.

(a) RESIDENCE NO. 735 N. Central Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. — mos. — ds. How long in U. S., if of foreign birth? 48 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: Frank. W Reed

6 DATE OF BIRTH (month, day, and year): Dec 1872

7 AGE: Years 50 Months 10 Days 11 If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Morris Keene

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Eliz Keene

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mr. Frank. G. Reed

(Address): 735 N. Central Ave.

15 Filed DEC 13 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1922, to Dec 13, 1922, that I last saw h alive on Dec 13, 1922, and that death occurred, on the date stated above, at 7.55 a.m.

The CAUSE OF DEATH* was as follows: Acute Cholecystitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Carcinoma.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) A. J. Sessaga M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Dec. 16 1922

20 UNDERTAKER: Henry Hough Son — ADDRESS: 1301 E Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful to see that NAME and AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. mation should be in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70033

D70033

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2829 Remington Ave ST.; 12 WARD)

2-FULL NAME Rhine Brooks

(a) RESIDENCE. No. 2829 Remington Ave ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Gertrude Brooks (Address) 2829 Remington Ave

15 Filed DEC 13 1922, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 1922 to Dec 11 1922

that I last saw h alive on Dec 11 1922

and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

Interstitial

(duration) yrs mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bacilli & Exam

(Signed) R. Garland Schmidt M. D.

(Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chesterfield Va

DATE OF BURIAL Dec 14 1922

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1125 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be careful to see that information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This is very important.

D70034

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70034

CERTIFICATE OF DEATH.

179

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Johns Hopkins Hosp ST.: 8 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Madaline Coles

(Residence in Baltimore: No. 1214 N. Wolfe St

St.; yrs., 10 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

N. B.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Black	Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 10 yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Austin Coles

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Nellie James

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Coles Miller

(Address) 1214 Wolfe St.

15-

Filed ....., 191....

Registrar.

DEC 13 1922

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 12, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental — 3rd degree burns over legs & abdomen &
(Clothes caught fire from
coal stove) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) burns by clothes
(Duration) 2 yrs. mos. ds.

(Signed) J. S. F. Salter M. D.
(Coroner.)

12-12, 1922 (Address) 308 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Arlington Cemetery — DATE OF BURIAL, Dec 15, 1922

20-UNDERTAKER Mrs Robert A Elwin — ADDRESS 1775 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70035 — CERTIFICATE OF DEATH. — D70035

38

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE, (No. ..... ST., 5 WARD)

2-FULL NAME Annie Kellam

(a) RESIDENCE No. 1404 Hunt Alley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 6 yrs. ..... mos. ..... ds.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Kellam

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: Years 43 Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia Hinterson

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Bayview Hospital Dover, Md.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

DEC 13 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1920 to Dec 11, 1922 that I last saw h[illegible] alive on Dec 11, 1922 and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Senile Cerebration

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) N. H. Dorsett Jr. M. D.

12/17/1922 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arlington Nat'l Cem. Va

DATE OF BURIAL: Dec 14 1922

20 UNDERTAKER: Jere Robert A Elliott

ADDRESS 1725 Ashland Av

Spec.—1-10-21—M&T—1500 Bks.

D70036

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70036

CERTIFICATE OF DEATH.

114

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2305 West North Ave. ST., 15 WARD)

2-FULL NAME Ann Virginia Albaugh

(a) RESIDENCE NO. 2305 West North Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Albaugh

6 DATE OF BIRTH (month, day, and year) Aug. 9, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lynchburg, Va.

PARENTS

10 NAME OF FATHER Michael Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Senorah Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Elizabeth N. Newport

(Address) 2305 W. North Ave.

15 Filed ....., 19 ..... Registrar

Burial Permit Clerk.

EC 13 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11/22 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 30/22, 19 ..... to Dec 11, 1922.

that I last saw h alive on Dec 10, 1922,

and that death occurred, on the date stated above, at 2.25 a.m.

The CAUSE OF DEATH* was as follows:

Senility (Edema) Age

Hypostatic Congestion of Both Lungs.

Chronic Enteritis 2 mos. ds.

CONTRIBUTORY (Secondary) Hardening of Cardiac Arteries (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. E. Hewitt, M. D.

, 19 (Address) 1907 Whyte.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 12/14/22 19

20 UNDERTAKER Henry W. Mears & Son — ADDRESS 805 N. Calvert

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70037

D70037

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 60 Washington ST.; 25 WARD) Brooklyn

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Dewalt

(a) RESIDENCE. NO. 60 Washington ST., 25 WARD. Brooklyn
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas R Dewalt 1856

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS
10 NAME OF FATHER Henry Dingle
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Benjamin Abbott
(Address) 601 Washington ave

DEC 13 1922 19 Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-11 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1922, to Dec 11, 1922, that I last saw h[illegible] alive on 12-11, 1922, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Four weeks ds.

CONTRIBUTORY (Secondary) Lagrippe (duration) Two weeks ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) L Huntington, M. D.
12/13/1922 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL Dec 14 1922

20 UNDERTAKER F A Kranse & Son

ADDRESS 2031 Hanover

N.B.—WRITE PLAINLY, WITH UNFADING INK—THE ... should be stated EXACTLY. PHYSICAL ... mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may ... may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70038

D70038

CERTIFICATE OF DEATH.

38 N

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dorsey

(a) RESIDENCE NO. 725½ W. Saratoga St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with unfading ink—THIS IS A LEGAL DOCUMENT. PHYSICIANS should make all entries carefully and exactly. PHYSICIANS should be careful and exact. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	40	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Anna Arundal Co.,
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Dorsey

11 BIRTHPLACE OF FATHER (city or town) Anna Arundal
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Anna Arundal Co.
(State or country) Maryland

14 Informant Municipal Hospital Records.
(Address)

15 Filed DEC 14 1922 19 ROBERT H. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 10 19 22

17

I HEREBY CERTIFY, That I attended deceased from Sept. 30, 19 22, to December 10 19 22.

that I last saw him alive on December 9, 19 22,

and that death occurred, on the date stated above, at 4:15 A.M.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency over

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocarditis

Insufficiency (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Aydelotte, M. D.

12/10/19 22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 12/16/22 19

20 UNDERTAKER R. L. Palan

ADDRESS 220 Walnut

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Syphilis

D70039

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70039

CERTIFICATE OF DEATH.

1835

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. St. Joseph's Hosp St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Jantso Chinn

(Residence in Baltimore: No. 105 Broad Alley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced (Write the word.): M

6-DATE OF BIRTH: Sept (Month) 15 (Day) 1861 (Year)

7-AGE: 61 yrs. 1 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): O.H.

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: unknown

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wife

(Address) 105 Broad Alley

15- DEC 14 1922 19.. ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 3 (Day) 192.7 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull - Fall while intoxicated

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

(Duration) ....yrs....mos....ds.

(Signed) J. J. Miller M. D. (Coroner.)

Dec 6 192.7 (Address) 5.U.S. E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL, ..., 19..

20-UNDERTAKER. ADDRESS

HOPKINS HOSPITAL

DEC 1 1922

THE MORGUE. 1935

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If LESS than 1 day state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70040

CERTIFICATE OF DEATH.

101-101

D70040

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1308 N. Gilmor ST. 15 WARD)

2-FULL NAME Colonel John W. Pettit

(a) RESIDENCE NO. 1308 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	75	7	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Politician

(b) General nature of industry, business, or establishment in which employed (or employer) Clerical

(c) Name of employer U.S. Government.

9 BIRTHPLACE (city or town) Westchester

(State or country) Pa.

PARENTS

10 NAME OF FATHER John D. Pettit

11 BIRTHPLACE OF FATHER (city or town) West Chester

(State or country) Pa

12 MAIDEN NAME OF MOTHER Henrietta Curtis

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia

(State or country) Pa

14 Informant (Address) Hannah Grey 1308 N. Gilmor St.

15 Filed DEC 14 1922 19 ROBERT E. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC- 11 - 1922

17 I HEREBY CERTIFY, That I attended deceased from December 9, 1922, to Dec 11, 1922, that I last saw him alive on Dec. 11, 1922, and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) 2 yrs. + mos. + ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles E. Clark, M. D.

12-12 1922 (Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 12/14/22 19

ADDRESS

20 UNDERTAKER H. E. Hughes 424 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT MUST BE WRITTEN EXACTLY. PHYSICIANS should carefully supply information. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70041

CERTIFICATE OF DEATH.

57 D70041

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 Eutaw Place ST., WARD)

2-FULL NAME Max S. Thankouser

(a) RESIDENCE No. 1719 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Sallie Thankouser

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer Merchant

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Philip Thankouser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Sidney Thankouser (Address) 1719 Eutaw Pl.

15 Filed DEC 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/12/1922.

17 I HEREBY CERTIFY, That I attended deceased from Jany 16, 1911, to Dec 12, 1922, that I last saw h alive on Dec 12, 1922, and that death occurred, on the date stated above, at 11 20 P m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus - 11 years Duration
Nephritis chronica - 8 yrs duration

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Isaac P. Hamburger, M. D.

Dec 13, 1922 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Heb. Cem.	12/15/1922
20 UNDERTAKER David Sondheim	ADDRESS 1180 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70042

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70042

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL ST., ... WARD)

2-FULL NAME Charles Bethel

(a) RESIDENCE NO. 902 N Duncan St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Infant mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. mation should be

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10-1922

7 AGE — Years 1 Months 3 Days — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Harry Bethel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Pfour

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed DEC 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1- 1922 to Dec 13 1922

that I last saw h alive on Dec 13 1922

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Congenital heart disease

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) Congenital syphilis

(duration) yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Wesch, M. D.

(Address) Johns Hopkins Hosp.

, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Dec 13 1922

20 UNDERTAKER Zerkel & Zerkel — ADDRESS 1739 Eager

D70043

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70043

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Lombard St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Weitman

(Residence in Baltimore: No. 39 So. Caroline St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Unknown
(Month) (Day) (Year)

7-AGE. 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Merchant
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pearl Weitman

(Address) 39 So. Caroline St.

15-DEC 14 1922 ROBERT R. KRAUTER,
Filed 192. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 13½ 192.2
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

or Colic

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) Thos. L. Norton M. D.
(Coroner)

Dec 14 1922 (Address) Curtis Bay, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Hebrew Rosedale

DATE OF BURIAL. 12/15 1922

20-UNDERTAKER. Jack Lewis

ADDRESS 1139 E Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. In stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70044

90

D70044

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 404 N Garrison Lane WARD 24)

2-FULL NAME Sarah R Murphey

(a) RESIDENCE NO. 404 N Garrison St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) or (WIFE of): James Murphey

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE: Years: About 62; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): W. Virginia

PARENTS

10 NAME OF FATHER: John Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Miss Sarah Murphey 404 N. Garrison Lane

15 Filed DEC 14 1922, 19 ; Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 13, 1922

that I last saw h e alive on Dec 12, 1922

and that death occurred, on the date stated above, at 11P m.

The CAUSE OF DEATH* was as follows:

Acute dilitation of Heart 3 hrs.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Myocarditis - arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? — No

What test confirmed diagnosis? Clinical

(Signed) W. S. Willitt, M. D.

Dec 13 1922 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 12-15- 1922

20 UNDERTAKER: H. C. Manning & Son — ADDRESS 517 N Belnord Ave

Spec. 1-10-21 M&T 1500 Blks.

D70045

HEALTH DEPARTMENT—CITY OF BALTIMORE D70045

CERTIFICATE OF DEATH. 45

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 27 WARD)

2-FULL NAME Carrie Spencer

(a) RESIDENCE NO. 316 Paca St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	~~Single~~ married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
50	--		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records.

(Address)

15 Filed DEC 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1922 to December 13, 1922.

that I last saw h. er alive on December 13, 1922.

and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration), 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

12/13/1922 (Address) per Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md.

DATE OF BURIAL Dec 15 1922

20 UNDERTAKER Robt T Turner Inc

ADDRESS 1442 N Broadway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70046 D70046

CERTIFICATE OF DEATH.

118-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1639 Hilton ST. 16 WARD)

2-FULL NAME Carrie Virginia Gregory

(a) RESIDENCE NO. 1639 Hilton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Henry D. Gregory

6 DATE OF BIRTH (month, day, and year) Apr. 2/1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennypacus Pa

PARENTS

10 NAME OF FATHER Robt. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Kelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant E. B. Gregory

(Address) 814 Aisquith Ave

15 Filed DEC 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/12, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1922, to Dec. 12, 1922, that I last saw her alive on Dec. 12, 1922, and that death occurred, on the date stated above, at 10:08 P. m.

The CAUSE OF DEATH* was as follows:

Chronic incomplete intestinal Obstruction.

(Exact cause not known)

(duration) yrs. 2½ mos ds.

CONTRIBUTORY (Secondary) Autointoxication

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Maurice E. Shamer, M. D.

12/13, 1922 (Address) 3300 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Dec 19 22

20 UNDERTAKER Wm Fickes & Sons

ADDRESS 714 Pa

Spec.—1-10-21 M&T 1500 Bks.

D70047

D70047 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Edmondson Ave ST. WARD)

2-FULL NAME Elizabeth Genevieve Dutton

(a) RESIDENCE NO. 1608 Edmondson Ave ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James T. Dutton

6 DATE OF BIRTH (month, day, and year) Oct. 24, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	54	1	19	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Sinclair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna E. Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Henry C. Morris (Address) 1608 E. Franklin St

15 DEC 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1922

17 I HEREBY CERTIFY, That I attended deceased from May, 1922, to Dec. 12, 1922, that I last saw h alive on Dec. 12 1922 and that death occurred, on the date stated above, at 4.53 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Gastro-enteritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Germain Cornell Mrse M. D.

1922 Address) 103 W. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem DATE OF BURIAL Dec 15 1922

20 UNDERTAKER Wm J. Luckner & Sons ADDRESS Lorraine

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE MUST BE FILLED OUT BEFORE BURIAL PERMIT IS ISSUED. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70048

D70048

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 Druid Hill ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm-E. Furgerson

(a) RESIDENCE NO. 939 Druid Hill ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Furgerson

6 DATE OF BIRTH (month, day, and year) Oct 8-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59 —	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Moving

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Arnold & Frederick

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Susan Furgerson (Address) 939 Druid Hill

15 DEC 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/11 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 ., 1921 , to Dec 11th , 1922.

that I last saw him alive on Dec 11th , 1922 ,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) 1 yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gustav Goldman, M. D.

12/12 1922 (Address) 1516 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

UNDERTAKER Samuel Hemsley

DATE OF BURIAL 12/14 1922

ADDRESS 578 N Eddle

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70049

D70049

CERTIFICATE OF DEATH. † 100-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME OLIVER GALLOP KENLY (Confederate Sold'r)

(a) RESIDENCE NO. Mercy Hospital ST., 4 WARD Home, Pikesville, Md)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? 84 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Alexine Kenly

6 DATE OF BIRTH (month, day, and year) Nov-?-1838.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. Retired-Pension-

(b) General nature of industry, business, or establishment in which employed (or employer) ed Soldier living

(c) Name of employer Confederate Home, Piksvlle

PARENTS

9 BIRTHPLACE (city or town) (State or country) Havre de Grace Maryland

10 NAME OF FATHER Richard Kenly

11 BIRTHPLACE OF FATHER (city or town) Havre de Grace (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Gallop

13 BIRTHPLACE OF MOTHER (city or town) Havre de Grace (State or country) Maryland

14 Informant Mrs Anna Helen Nock, (daughter) (Address) Saulsbury, Md.

15 Filed DEC 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1922, to Dec 13, 1922, that I last saw him alive on Dec 13, 1922, and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

Bronchus Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia + acute heart failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin + Sequ

(Signed) [illegible] M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross (Balto. City)	Dec-15-22
20 UNDERTAKER STEWART & MOWEN COMPANY, WILLIAM F. WOODEN, Successor	ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Form No. 1 10-21—MAT—1500 Blks.

D70050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70050

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1610-Bolton-Street ST., 14 WARD)

2-FULL NAME ELIZABETH ANN MAY

(a) RESIDENCE NO. 1610-Bolton-St. ST., 14 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 2 mos. 18 ds. How long in U. S., If of foreign birth? 82 yrs. 2 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) Sept-25-1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	82	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James W. May

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss Mary E. Dean, (niece)
(Address) 1610-Bolton-St., City.

15 DEC 14 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1922, to Dec 13, 1922, that I last saw h.r alive on Dec 12, 1922 and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) ...yrs. ...mos. 2 dy.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) ...yrs. ...mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. M. Cashare, M. D.

, 19 (Address) 1603 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL GREENMOUNT CEMETERY — DATE OF BURIAL DEC-15-22

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS MATTER MUST BE STATED EXACTLY. AGE should be carefully supplied. If it may be properly classified. E mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70051

D70051

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6010-Foster-Av. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Snowden Wheeler

(a) RESIDENCE NO. 6010-Foster-Av. ST., 27 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? 64 yrs. 9 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida May Wheeler

6 DATE OF BIRTH (month, day, and year) Feby-15-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist.

(b) General nature of industry, business, or establishment in which employed (or employer) Machinery.

(c) Name of employer Penna. R. R. Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph A. Wheeler.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Disney

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Joseph Wilson, (son)
(Address) 6010-Foster-Av. Govans.

15 Filed DEC 14 1922 ROBERT R. KRAUTER, Registrar
Chief Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec -12- 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to Dec 12th, 1922, that I last saw h[illegible] alive on Dec 12th, 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septic poisoning from abscess of foot (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. H. Duncan, M. D.

12.13 1922 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK CEMETERY — DATE OF BURIAL: DEC-15-22

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 103 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED EXACTLY AS REQUIRED BY LAW. AGE should be carefully supplied. mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

3 Should this be stated EXACTLY ent of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D70052 HEALTH DEPARTMENT—CITY OF BALTIMORE D70052

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 6 ST., Robert Thomas WARD)

2-FULL NAME

(a) RESIDENCE NO. 500 E. 27th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma V. Cunningham

6 DATE OF BIRTH (month, day, and year) Feb 20 1860

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary

(b) General nature of industry, business, or establishment in which employed (or employer) Y.M.C.A 809

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bulle Md

PARENTS

10 NAME OF FATHER Wm Thomas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizth Rawlings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A A Co. Md

14 Informant Chas E Cunningham

(Address) 522 E 27th St

15 Filed DEC 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 11 1922

17 I HEREBY CERTIFY, That I attended deceased from November 2, 1922, to Dec. 11, 1922,

that I last saw him alive on Dec. 11, 1922,

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

1. Hypertrophy of Prostate Gland

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Nov 16-1922

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) James Hubert Wilkinson M. D.

(Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	12/14/1922

20 UNDERTAKER C. J. Fanning & Son 1938 ADDRESS Lafayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70053

CERTIFICATE OF DEATH. 1-001

D70053

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 S Bond ST., 2 WARD)

2-FULL NAME Stephen Bartasiak

(a) RESIDENCE NO. 613 S Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. Items must be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna Bartasiak

6 DATE OF BIRTH (month, day, and year) Dec 22 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	50	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Central Foundry

(b) General nature of industry, business, or establishment in which employed (or employer) Dundalk

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Bartasiak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Krawczyk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anna Bartasiak
(Address) 613 S Bond St

15 DEC 14 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 7th, 1922, to Dec 13th, 1922, that I last saw h— alive on Dec 10th, 1922, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) A. Flax, M. D.

Dec 13, 1922 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Dec 15 1922

20 UNDERTAKER John M Weber — ADDRESS 1803 Bank St

D70054

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70054

181-001

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 520 S First St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos R. Brown.

(Residence in Baltimore: No. 520 S First St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, June (Month) 30 (Day), 1870 (Year)

7-AGE, 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Dr
(b) General nature of industry, business, or establishment in which employed (or employer)..... Specialist

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Brown

(Address) 526 S 1st St

15- Filed DEC 14 1922 191.....

ROBERT R. KRAUTER, Clerk.
Burial Permit Issuer.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 8 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by me at said Inquest, and ..... find that said deceased came to death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Asphyxiation by Illuminating Gas

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gas jet open

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B. Horton M. D.

Doctor (Address) Curtis Bay, Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, 12/11, 1922

20-UNDERTAKER George J Ruth

ADDRESS 1130 Harford Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY WITH INK

Addaine Miller

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D70055

D70055

CERTIFICATE OF DEATH. 100-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 Valley View ave ST.) (16 WARD)

2-FULL NAME Addaine Miller.

(a) RESIDENCE NO. 212 Valley View ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~1~~ yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) March 7th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
		9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Michael Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Katherine Long

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant (Address) Michael Miller 212 Valley View ave

15 Filed DEC 14 1922 19 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to Dec 13, 1922

that I last saw h e alive on Dec 12, 1922

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Bronchs-Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Teething Cold

(duration) yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. A. Hoff, M. D.

12/13 1922 (Address) Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec 15 1922

ADDRESS 1203

20 UNDERTAKER Henry Lutz N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 **D70056**

D70056

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1934 E. Chase ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Merrick W. Southcomb

(a) RESIDENCE NO. 1934 E. Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Paul W. Southcomb

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Evelyn Andrews

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mrs Southcomb
(Address) 1934 E. Chase

15 Filed DEC 14 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1922, to Dec 13, 1922, that I last saw him alive on Dec 12, 1922, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Pulmonate

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

What test confirmed diagnosis? Clinical

(Signed) H. S. Carman, M. D.

12-14, 19 (Address) 1707 N Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 15 1922
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70057 | CERTIFICATE OF DEATH. | 181-601 | D70057

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1443 Eastern Ave St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. William Homyer

(Residence in Baltimore: No. 1443 Eastern Ave St.; yrs. 52 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH. Unknown (Month) (Day) (Year)

7-AGE. 66 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Rudolph Homyer

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Homyer Jr

(Address) 207 E. Pratt St

15- Filed DEC 14 1922 ROBERT P. KNAUER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 12 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Asphyxiation by Illuminating Gas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. T. Norton M. D.
(Coroner)

Dec 14 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Lakewood Cem. DATE OF BURIAL. Dec 14 1922

20-UNDERTAKER. Randall J Hoppel ADDRESS 100 S. Washington

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D70058

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1325 James ST.: 21 WARD)

2-FULL NAME Frank Shepard Ellis

(a) RESIDENCE. No. 1325 James ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married Nellie Ellis

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Ellis

6 DATE OF BIRTH (month, day, and year) Feb 27, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Swindell Bros

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Edw. H. Ellis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Flonnie E. Barnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New [illegible]

14 Informant Harry C. Ellis

(Address) 434 East 1st Northern

Filed DEC 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/13/22.

17 I HEREBY CERTIFY, That I attended deceased from 12/6/22. 19 . to 12/13/22. 19 .

that I last saw him alive on 12/13/22. 19 .

and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris, M. D.

12/13 19 23 (Address) 1430 Lanvale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	12/16/22

20 UNDERTAKER Wm Cook ADDRESS 6026 Reisterstown

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. All information should be carefully supplied. AGE should be stated EXACTLY. Fractions of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D70059

REGISTERED NO.

D70059

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2713 Allen ave ST. | 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. DeVaughn

(a) RESIDENCE. No. 2713 Allen ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Widower

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Mary E DeVaughn.

6 DATE OF BIRTH (month, day, and year) March 19 1837.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Georges Co. Maryland.

PARENTS

10 NAME OF FATHER Henry DeVaughn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Francis A. DeVaughn (Address) 2713 Allen ave.

15 DEC 14 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8 1922, to Dec. 12, 1922, that I last saw h~~im~~alive on Dec. 11, 1922, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

- Paralysis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? at this Home.

Did an operation precede death? No Date of -

Was there an autopsy? No.

What test confirmed diagnosis? Visible Paralysis.

(Signed) Julian P. Ibell M. D.

, 19 (Address) Wyliesville Rockville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	12/15 19 22
20 UNDERTAKER	ADDRESS
Ingworth & Son	611 Eastern Ave

Information should be carefully supplied. Exact statement of occupation may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70060

CERTIFICATE OF DEATH.

90

D70060

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 N Collington ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles R. Tuttle

(a) RESIDENCE NO. 1817 N Collington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of May 14 1859

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Thomas Tuttle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Sonia Kunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Carl A Stevenson

(Address) 1817 N Collington Ave

15 Filed DEC 14 1922 ROBERT R. KRAUSER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1922, to Dec 12, 1922,

that I last saw him alive on Dec 5, 1922,

and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Fisher, M. D.

12/13 1922 (Address) 1823 N. Mast St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park DEC. 15 1922

DATE OF BURIAL

20 UNDERTAKER: Wm Cook

ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH INK. AGE should be stated EXACTLY as near as information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70061

CERTIFICATE OF DEATH.

31

D70061

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 N. Stricker ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen E. Stover (nee Ellen E. Straley)

(a) RESIDENCE. NO. 230 N. Stricker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Stover

6 DATE OF BIRTH (month, day, and year) May 8, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	53	7	6	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Adams Co., Pa.

PARENTS

10 NAME OF FATHER Samuel Straley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant H. E. Phillips (Address) 939 E. Preston St.

DEC 14 1922

Robert F. Carlson, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1919, to December 14, 1922, that I last saw her alive on December 13, 1922, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

over (duration) 3 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) None (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Phys. + 24. + Sputum 24.

(Signed) Henry L. Ohler, M. D.

, 19 (Address) 1203 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Oxford Pa.

DATE OF BURIAL: Dec. 16 1922

20 UNDERTAKER: W. J. Tickenor & Sons

ADDRESS: Orrtanna Pa

CB.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70062

CERTIFICATE OF DEATH.

74-001 D70062

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 347 S. Calhoun St., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Golden

(Residence in Baltimore: No. 347 S Calhoun St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	W	Widow

6-DATE OF BIRTH, Unknown ..... (Month), 1 ..... (Day), ... (Year)

7-AGE, about 80 years	If LESS than 1 day, ...hrs. or ....min.?
....yrs. ....mos. ....ds.	

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John McMahon

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Nancy Carmichael

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Lagan

(Address) 347 S. Calhoun St.

15-

DEC 14 1922 ..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 12 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 5 1922, to Dec 12 1922, that I saw her alive on Dec 11 1922, and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Fred. D. Jarrett M. D.

Dec 12, 1922 (Address) 2216 Penna Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudenslager — DATE OF BURIAL, Dec. 15 1922

20-UNDERTAKER Martin Starkey & Son — ADDRESS 1877 N. North Ave.

NB.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70063

D70063

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH 1800

CITY OF BALTIMORE: (No. 1700 N Mount St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert G Tinkler

(a) RESIDENCE. NO. 1800 N Mount St St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Maggie Tinkler

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bell Telephone Co

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Samuel Tinkler

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Annie Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Maggie Tinkler (Address) 1700 N Mount St

15 Filed Dec 18 1922 Robert P. Harrison, Registrar

Burial Permit Sent.

N. B.—WRITE PLAINLY. WITH CARE. AGE should be stated EXACTLY. Full information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be

8 14 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1922

17 I HEREBY CERTIFY, That I attended deceased from May, 1922, to Dec 14, 1922, that I last saw him alive on December 13, 1922, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? All T.B. Tests

(Signed) Charles J Wells, M. D.

, 19 (Address) 2 W Belvedere ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greathedral Cem

DATE OF BURIAL Dec. 18 1922

20 UNDERTAKER M Tuskey & Sons. ADDRESS 1821 W N Ave

Spec.—1-10-21—M&T—1500 Bks.

(See affadirit over) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70064

D70064

44

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2305 W. Lanvale St. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Marshall Wall

(a) RESIDENCE NO. 2305 W. Lanvale St. ST., .. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida M. Wall

6 DATE OF BIRTH (month, day, and year) March 20" 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Burrells Bay Va.

PARENTS

10 NAME OF FATHER ~~Alexander M.~~ John Wall

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Susanna ~~Wall~~ Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Alfred V. Wall

(Address) 2305 W. Lanvale St.

15 Buried Burial Point, [illegible]

Registrar

DEC 14 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14" 19 22

17

I HEREBY CERTIFY, That I attended deceased from April 1", 1922, to Dec 14", 1922

that I last saw h[illegible] alive on Dec 10", 1922

and that death occurred, on the date stated above, at 7.35 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Peylorus + Duodenum

(duration) 1 yrs.) mos) ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) 1 yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical test + Consultation

(Signed) Thomas J. Talbott M. D.

12/14/22, 19 (Address) Marlborough Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Dec 15" 1922

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 W. Balto St

C. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. mation should be carefully supplied. AGE should be properly classified. so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Association]

Alfred V. Wall personally appeared before me this 2nd. day of January 1923, and made affadavit that the name of the father Alexander M. Wall should be John Wall instead of Alexander M. and the mother's name should be Susanne Barker instead of Susanna Wall.

Alfred V. Wall.

Subscribed and Sworn to before me this 2nd. day of January 1923.

Reed Gaither
Notary Public.

Bronchopneumonia ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70065

D70065

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise St. Cassell

(a) RESIDENCE NO. 2603 Hilton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Married

5a If married, ~~widowed or divorced~~ (~~HUSBAND~~) of (or) WIFE of John S. Cassell

6 DATE OF BIRTH (month, day, and year) Feb 16 1856

7 AGE	Years	Months	Days	11 LESS than 1 day, ... hrs. or ... min.
	66	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) London England

12 MAIDEN NAME OF MOTHER Josephine Tilyard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) John S. Cassell 4100 Springdale Ave

15 Filed DEC 14 1922 Robert P. Hartigan, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 14 1922

17 I HEREBY CERTIFY, That I attended deceased from December 12 1922 to Dec 14 1922

that I last saw her alive on Dec 14 1922

and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Gangrenous leg and acidosis (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical History, Symptoms

(Signed) Chas. Wilbur Stewart M. D.

12/14 1922 (Address) 1738 E. 28th St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL Dec 16 1922

20 UNDERTAKER Geo W Little ADDRESS EDMONDSON AVE.

(Udora M. Bailey) ✓

Spec.—6-9-19—H P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70066 D70066

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 663 E Clements St.: 2d WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Udora M. Bailey

(a) RESIDENCE. No. 663 E. Clement St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. T. Bailey

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Helen Gregory (Address) 663 Clements

15 Filed DEC 14 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1922, to Dec 13, 1922, that I last saw h-e alive on Dec. 13, 1922, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W. J. Seabury, M. D.

12/14/1922 (Address) 688 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Hill Cem	12/15 1922
20 UNDERTAKER J. F. Talley & Sons	ADDRESS 316 Eight St.

R.—WRITE PLAINLY. All items must be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70067

CERTIFICATE OF DEATH.

164

D70067

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 848 Harlem Ave ST.: 18 WARD)

2-FULL NAME Due Marchant

(a) RESIDENCE. NO. 848 Harlem Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 12 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia USA (State or country)

PARENTS

10 NAME OF FATHER Ambrose Marchant

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Mildred Esther Fleet

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Mrs Leonora Marchant (Address) 848 Harlem ave

15 DEC 15 1922 RMK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1922, to Dec 14, 1922, that I last saw her alive on Dec 11, 1922, and that death occurred, on the date stated above, at 1030 A m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) long yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) N. E. Jones, M. D.

, 19 (Address) 720 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Dec 16 1922
20 UNDERTAKER Addie M. Walker	ADDRESS 423 W Lafayette St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in YEARS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70068

CERTIFICATE OF DEATH.

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5149 Park Heights Avenue 27 WARD)

2-FULL NAME Augusta Harris

(a) RESIDENCE NO. New York City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Isaac Harris

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Soloman Gerscther

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Gella Adam

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant J. Lewis
(Address) 1439 E. Balto St.

15 DEC 15 1922 RRK. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 14 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 15 , 19 22 , to Dec 14 , 19 22 ,
that I last saw her alive on Dec 14 , 19 22 ,
and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Diabetis Mellitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of Heart & Urine

(Signed) Gains N. Bellup, M. D.

, 19 (Address) 2224 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
New York City, N.Y.

DATE OF BURIAL 12-15 19 22

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Balto.

N. B.—WRITE PLAINLY, WITH INK. All items must be supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D70069 HEALTH DEPARTMENT—CITY OF BALTIMORE D70069

CERTIFICATE OF DEATH. 1462

1-PLACE OF DEATH Homewood Hospital

CITY OF BALTIMORE: (No. 2724 N. Charles St ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Atkins

(a) RESIDENCE NO. 1022 Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Atkins

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edward B. Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georges Maryland

12 MAIDEN NAME OF MOTHER Mary Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Brother - Mr. Clinton Griffin (Address) 5 Worcester Ave - Arlington

15 Filed DEC 15 1922 19 R.R.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 . 1922 to Dec 14 . 1922

that I last saw h[illegible] alive on Dec 13 . 1922

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Puerperal infection (Auto infection) following 7 mo miscarriage (Exhaustion)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paresis.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at her home

Did an operation precede death? yes Date of Dec 5/22

Was there an autopsy? no

What test confirmed diagnosis? Typ[illegible] temp Symptoms

(Signed) Chas A Fleischhauer M. D.

. 19 (Address) 1807 W Mt Royal ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Dec 16 1922

20 UNDERTAKER Mr & Mrs N. S. Frick

ADDRESS 1727 Pratt St

D70070

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70070

CERTIFICATE OF DEATH.

199

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME, Jacob Fowler

(Residence in Baltimore: No. 300 W Carlton St St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced. (Write the word.): Sigle

6-DATE OF BIRTH: (Month) Apl (Day) 8 (Year) 1857

7-AGE: 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto City

PARENTS:
10-NAME OF FATHER: Jacob Fowler
11-BIRTHPLACE OF FATHER, (State or Country): Balto City
12-MAIDEN NAME OF MOTHER: Emelia White
13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emelia Fowler

(Address) 300 W Carlton St

15-Filed DEC 15 1922 R R K Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Dec (Day) 11 (Year) 1922

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or [redacted]) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Simple fracture of leg

(Duration) yrs. mos. 7 ds.

(Signed) W H Grason M. D.
(Coroner.)

12-14 1922 (Address) 117 W Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Mt Auburn ct — DATE OF BURIAL: Dec 16 1922

20-UNDERTAKER: [illegible] — ADDRESS: [illegible]

N. B.—Every item of information should be carefully answered, so that it may be properly classified. Exact statements should be made. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements should be made. Be sure to fill out every item of certificate. See instructions on back of certificate. is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70071 D70071

CERTIFICATE OF DEATH.

159-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1422 Aisquith ST., 9 WARD)

2-FULL NAME Infant of Jennie M. & John A. Schreiber

(a) RESIDENCE NO. 1422 Aisquith ST., 9 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? Lif yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Sing'l.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 14 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER John A. Schreiber

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Jennie M. Moeller

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant John A. Schreiber (Address) 1422 Aisquith St

15 DEC 15 1922 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1922

17 I HEREBY CERTIFY, That I attended deceased from December 14, 1922, to December 14, 1922, that I last saw h. alive on December 14, 1922 and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure at birth.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William F. Schwartz, M. D.

12/14, 1922 (Address) 1200 N. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemy DATE OF BURIAL Dec 15 1922

20 UNDERTAKER Henry Hoeck Sons ADDRESS 1301 E Eager

N. B.—WRITE PLAINLY, WITH CARBON. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70072

CERTIFICATE OF DEATH.

185 D70072

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2400 Brookfield ave (St.) 13 (Ward)

2-FULL NAME Caroline Juhn

(a) RESIDENCE. No. 2400 Brookfield ave St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Juhn

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Salomon Juhn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Esther Schmid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sidney Wolfsheimer

(Address) 2400 Brookfield ave

15 Filed . 19 Registrar

DEC 15 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1922, to Dec 13, 1922, that I last saw her alive on Dec 12, 1922, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Fall down Steps

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Davis, M. D.

. 19 (Address) 2108 Brookfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cem

DATE OF BURIAL 12/15 1922

20 UNDERTAKER J. Ahrens Co.

ADDRESS 1611 Madison

N. B.—Write should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70073

CERTIFICATE OF DEATH.

100-a

REGISTERED NO. C

D70073

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 W Saratoga St. 17th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Thompson

(Residence in Baltimore: No. 411 W Saratoga St. St.: 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct. (Month) 3 (Day), 1862 (Year)

7-AGE, 60 yrs. 2 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Thompson

11-BIRTHPLACE OF FATHER (State or Country), American

12-MAIDEN NAME OF MOTHER Simmons

13-BIRTHPLACE OF MOTHER (State or Country), America

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugene Harbaugh

(Address) 411 W. Saratoga St.

15-

Filed DEC 15 1922 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 13th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st 1922 to 13th Dec 1922, that I saw h in alive on Dec 13th 1922, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

(a) Bronco Pneumonia

(Duration) ....yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) ....yrs. mos. 1 ds.

(Signed) Frank W Gunner M. D.

Dec 14, 1922 (Address) 310 N Gaurens

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Dec. 16.., 1922

20-UNDERTAKER George L Lohmeyer — ADDRESS 1101 Druid Ave.

N.B.—Every item of information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D70074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D70074

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 N Stanford av ST.; 9 WARD)

2-FULL NAME Virgin F. Mitchell.

(a) RESIDENCE. No. 16 N Stanford av ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed or Divorced~~ (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Mitchell

6 DATE OF BIRTH (month, day, and year) Christmas

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West Va.

PARENTS

10 NAME OF FATHER John Kemble

11 BIRTHPLACE OF FATHER (city or town) (State or country) West. Va.

12 MAIDEN NAME OF MOTHER Virgin F. Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va.

14 Informant Emma F. Blum.
(Address) 1635 Hanford ave

15 Filed DEC 15 1922 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 19 22

17

I HEREBY CERTIFY, That I attended deceased from Aug 14 19 21 to Dec 12 19 22

that I last saw h alive on Dec 12 19 22

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 3 mos. 29 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W. Donaldson, M. D.

19 (Address) 1714 N Carrollton av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec. 15 1922
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Hanford ave.

mation should be carefully supplied. Any ... should be ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

D70075

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70075

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Mercy Hospital St. 7 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas L. Hawthorn

(Residence in Baltimore: No. 345 Rosebank av— St.; yrs. 58 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White	Married

6-DATE OF BIRTH. March (Month) 14 (Day) 1862 (Year)

7-AGE. 60 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman Printing Shop
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Pa.

PARENTS.

10-NAME OF FATHER. Dont Know

11-BIRTHPLACE OF FATHER. (State or Country). Pa.

12-MAIDEN NAME OF MOTHER. Margarte White

13-BIRTHPLACE OF MOTHER. (State or Country). Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna J. Hawthorn

(Address) 345 Rosebank av

15- DEC 15 1922 192.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 14 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or,~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, or autopsy or,~~ inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(Duration) yrs. Dont know mos. ds.

CONTRIBUTORY (Secondary) La Grippe

(Duration) yrs. Dont know mos. ds.

(Signed) H K Jones M. D. (Coroner.)

12-15 1922 (Address) 117 W Saratoga st

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore	Dec. 18 1922
20-UNDERTAKER. Zirkler & Zirkler	ADDRESS 1739 Eager

N. B.—Every item of information should be given, so that it may be properly classified. Exact and full answers should be made to each question. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact and full answers should be made to each question. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact and full answers should be made to each question. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact and full answers should be made to each question. Be sure to state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70076

CERTIFICATE OF DEATH.

129 / D70076

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 China ST.: 22 WARD)

2-FULL NAME Alphonse Richards

(a) RESIDENCE. NO. 608 China ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waterman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Gulto

PARENTS

10 NAME OF FATHER: Anton Richards

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eliz Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anton Richards (Address) 1017 Light st

15 Filed DEC 15 1922 RMK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 14 1922 to Dec 13 1922, that I last saw h[illegible] alive on Dec 12 1922, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address) 602 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Dec 15 19

20 UNDERTAKER: F. A. Kramer & Son — ADDRESS: 703 Hanover

A. H. [illegible] nation should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70077

CERTIFICATE OF DEATH.

31 D70077

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 25 S. 11th ST., No. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Broening

(a) RESIDENCE NO. 25 S. 11th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Annie E. Broening

6 DATE OF BIRTH (month, day, and year): Nov 25-66

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boy

(b) General nature of industry, business, or establishment in which employed (or employer): Maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John Broening

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Annie E. Broening

(Address): 25 S 11th St

15 Filed DEC 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Dec. 12, 1922, that I last saw him alive on Dec. 12, 1922, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) E. L. Pearson, M. D.

12.14.22. (Address) Ten Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL 12/16 1922

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Aliceanna

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated correctly. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70078

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70078

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4805 Fleet ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Averle

(a) RESIDENCE NO. 4805 Fleet ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Wm Averle

6 DATE OF BIRTH (month, day, and year): Jan 22-52

7 AGE: Years 70 Months 10 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Philip Dalenz

(Address): 4805 Fleet St

15 Filed DEC 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 13 1922

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1922, to Dec 13, 1922,

that I last saw h alive on Dec 13 22, 19

and that death occurred, on the date stated above, at 11 05 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Senile Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Runke M. D.

, 19 (Address) 3042 Hudson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: 12/16 1922

20 UNDERTAKER: Philip Herwig — ADDRESS 206 Adams

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated CAREFULLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70079 — CERTIFICATE OF DEATH — D70079

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 407 Park Ave ST., Gorgas town WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Griffin

(a) RESIDENCE NO. 407 Park Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Joseph. F. Griffin

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 69 Years | Months | Days | If LESS than 1 day, hrs. or min.
about 69

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pima

PARENTS

10 NAME OF FATHER: Louis Ritter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Schwabs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Joseph F. Griffin Gorgas town
(Address): 407 Park Ave.

15 Filed DEC 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 13, 1922, that I last saw h[illegible] alive on Dec 13, 1922, and that death occurred, on the date stated above, at 11.05 a.m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) many yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo W. Stocking, M. D.

, 19 (Address) 5835 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Presbyterian Loans — DATE OF BURIAL: 12/16 19 22

20 UNDERTAKER: Wm Ecroto — ADDRESS: 50 E Mt

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70080

CERTIFICATE OF DEATH.

181-005

D70080

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2208 Guilford Ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Allen B. Robinson

(Residence in Baltimore: No. 2208 Guilford Ave St.; 23 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 18, 1883
(Month) (Day) (Year)

7-AGE, 39 yrs. 9 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Cashier 109
(b) General nature of industry, business, or establishment in which employed (or employer) Room Corbett Seed Co

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Mayor B Robinson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Louisa

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vernon Robinson

(Address) 2208 Guilford Av.

15- DEC 15 1922

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon Monoxide Poisoning
Accidental

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) M. D.
(Coroner.)

Dec 15, 1922 (Address) 432 N Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, 12/16/, 1922

20-UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70081

CERTIFICATE OF DEATH.

49 D70081

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2916 Walbrook Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Armstrong

(a) RESIDENCE NO. 2916 Walbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 87 yrs. 10 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 17 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	87	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Solomon Armstrong

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant James O Armstrong (Address) 2916 Walbrook Ave

15 Filed DEC 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14" 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5" 1922, to Dec 14" 1922, that I last saw him alive on Dec 13" 1922, and that death occurred, on the date stated above, at 5-30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bowel and Liver

(duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Arrhythmia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herbert E. Gerke M. D.

Dec 15 1922 (Address) 3048 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorrain Cemetery

DATE OF BURIAL Dec 16 1922

20 UNDERTAKER George J Smith

ADDRESS 1532 Mullins

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70082
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

100-001

D70082
Registered No. C.....

City of BALTIMORE: (No. 1037 N. Durham St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Gladys M. Tucker

(Residence in Baltimore: No. 1037 N. Durham St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Single

6-DATE OF BIRTH. Sept 15, 1922
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
....yrs. 3 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Jos L. Tucker

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Ida Mott

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ida Tucker
(Address) 1037 Durham

15-
Filed ... 192.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 13, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner.)

12-13 1922 (Address) 588 6 Northern

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Dec 15, 1922
20-UNDERTAKER.	ADDRESS
Mrs Robert L Elliott	Oakland Ave

N. B.—Every item of information should be given as accurately as possible, so that it may be properly classified. Exact information is very important. See instructions on back of certificate.

D70083 HEALTH DEPARTMENT—CITY OF BALTIMORE D70083

CERTIFICATE OF DEATH. 74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 929 Sterling St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Beard

(Residence in Baltimore: No. 929 Sterling St.; yrs. 41 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Single

6-DATE OF BIRTH, Feby 14 1875 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
45 yrs. 10 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Building

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Joshua Beard

11-BIRTHPLACE OF FATHER, (State or Country), Balto Co Md

12-MAIDEN NAME OF MOTHER, Sarah J. Bennett

13-BIRTHPLACE OF MOTHER, (State or Country), Balto City Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah E Beard (sister)

(Address) 613 N. Carolina

15-

Filed DEC 15 1922 192.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 14 192 2 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia
(Attended promptly on)
(only two hours)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) 0 yrs. mos. ds.

(Signed) Jos H Baer M. D. (Coroner.)

12-14 192 2 (Address) 545 E Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Dec 16 192 2
20-UNDERTAKER,	ADDRESS,
Mrs Robert A Elliott	1725 Oakland Ave

N. B.—Every item of information should be given. Each question should be properly answered. Do not state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70084

CERTIFICATE OF DEATH.

90

D70084

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

2-FULL NAME David Edwards

(a) RESIDENCE NO. 522 Asquith St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE plainly, and be careful to see that every question is carefully answered. AGE should be carefully supplied. Exact statement of occupation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER Bill Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Municipal Hospital Records. (Address)

15 FILED DEC 15 1922 K M K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 9 1922

17 I HEREBY CERTIFY, That I attended deceased from December 8, 1922, to December 9, 1922, that I last saw him alive on December 8, 1922, and that death occurred, on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde M. Reed, M. D.

12/9/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laural Cemetery

DATE OF BURIAL Dec 15 1922

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Ashland Av

Bertha Peck

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70085 D70085

CERTIFICATE OF DEATH.

170

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 100 N. Front St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha A Peck

(Residence in Baltimore: No. 100 N. Front St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Col	Single

6-DATE OF BIRTH.

..... (Month) ..... (Day) 1..... (Year)

7-AGE. 30 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Servant maid
(b) General nature of industry, business, or establishment in which employed (or employer): Waitress

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. S. Riley M.S. Coroner

(Address) 1639 N. Broadway

15. DEC 15 1922 19.. RMK Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 10 (Day) 22 192.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy ~~or inquiry~~.) thereon and from the evidence obtained by said Inquest and autopsy (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by pistol shot wound in brain

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. S. Riley M. D. (Coroner)

DEC 14 1922 (Address) 1639 Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Dec. 15th 1922
20-UNDERTAKER.	ADDRESS
E. J. Fanning & Bro.	1386 Lafayette

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

Szczukowski. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70086 D70086

CERTIFICATE OF DEATH. 101-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 Aliceanna ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Szczukowski

(Residence in Baltimore: No. 1724 Aliceanna St.; 42 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. Feb. (Month) 3 (Day), 1846 (Year)

7-AGE. 76 yrs. 10 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). At Home.

9-BIRTHPLACE, (State or Country), Germany Poland

PARENTS.

10-NAME OF FATHER, Jacob Klein

11-BIRTHPLACE OF FATHER (State or Country), Germany Poland

12-MAIDEN NAME OF MOTHER Mary Adwocki

13-BIRTHPLACE OF MOTHER (State or Country), Germany Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Szczukowski

(Address) 1707 S. Regester St.

15- Filed DEC 15 1922 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 9 1922, to Dec 14 1922, that I saw h[er] alive on Dec 14 1922, and that death occurred, on the date stated above, at 11[40] a m.

The CAUSE OF DEATH* was as follows:

R. Lobar Pneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Newman Silver M. D.

Dec 14, 1922 (Address) 1800 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem.

DATE OF BURIAL, Dec. 18, 1922.

20-UNDERTAKER W. F. Sadowski

ADDRESS 705 S. Ann St

N.B.—Every item of information should be given, so that it may be properly classified. Particularly important. See instructions on back of certificate.

D. 70087

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70087

CERTIFICATE OF DEATH.

✓ D. 70087

D70087

71-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital (St.) (Ward)

2-FULL NAME Mary A Pugh

(a) RESIDENCE NO. 3905 Foster Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20 1905

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
17	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER William B. Pugh

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Christina Schluter

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Christina Pugh (Address) 3905 Foster Ave

15 DEC 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1922 to Dec 13, 1922

that I last saw her alive on Dec 13, 1922

and that death occurred, on the date stated above, at 4:00 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 8hrs. ds.

CONTRIBUTORY (Secondary) Cerebro spinal Meningitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Newmarket, Va 10 PM

Did an operation precede death? Yes Date of 12/12/22

Was there an autopsy? No

What test confirmed diagnosis? Spinal Puncture

(Signed) J. H. Schaeffer M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: Dec. 17 1922

20 UNDERTAKER: H. Sander Sons

ADDRESS: 1310 Riadle

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70088

CERTIFICATE OF DEATH.

90

D70088

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3827 Fait Ave ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Smoot

(a) RESIDENCE NO. 3827 Fait Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis M. Smoot

6 DATE OF BIRTH (month, day, and year) Sept 28, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bullo (State or country) Md.

PARENTS

10 NAME OF FATHER David Sullens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sallie Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Elsie Perkins (Address) 3827 Fait Ave

15 Filed DEC 15 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from December 5, 1922, to December 13, 1922, that I last saw her alive on December 12, 1922, and that death occurred, on the date stated above, at 5 45 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Valvular Disease Heart (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? ~ Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Cobel V Athey, M. D.

Dec 14 1922 (Address) 100 S. Potterson Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL Dec 16 1922

20 UNDERTAKER H. Sander Sons

ADDRESS 1710 Park St.

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70089

D70089

CERTIFICATE OF DEATH.

99-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor, ST.) 10 (WARD)

2-FULL NAME. Rose Dailey,

(a) RESIDENCE. NO. Preston & Valley St. ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
85	unknown	unknown	not known	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer: " "

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Thomas Dailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Florence (Address) Preston & Valley Sts.

15 Filed Dec 15 1922 Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 19 to Dec 14 1922,

that I last saw h[illegible] alive on Dec 13 1922,

and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

2 Days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hamilton (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Dec 15 1922 (Address) 1138 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery Hartdale — DATE OF BURIAL: Dec 16 1922

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 924 E Eager St.

DEC 15 1922

mation should be carefully supplied. Any blanks must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D70090

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70090

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 63 Powell Ave ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary K. Reather.

(a) RESIDENCE NO. 63 Powell Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17 - 1865

7 AGE: Years 57 Months 5 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Chas H. Reather

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wash D.C.

12 MAIDEN NAME OF MOTHER: Annie E. McCaffety

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Wm Reather

(Address): 63 Powell Ave

15 Filed . 19 Registrar

Robert P. Carlson,

Burial Permit Clerk.

DEC 15 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 15 - 1922

17 I HEREBY CERTIFY That I attended deceased from Dec 13th, 1922, to Dec 15th, 1922, that I last saw her alive on Dec 14, 1922, and that death occurred, on the date stated above, at 330 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos 2 days ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert G Wheeler M. D.

1922 (Address) 703 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: Dec 18 1922

20 UNDERTAKER: Wm Cook

ADDRESS: 1508 E. Fayette.

N.B.—WRITE plainly and fill in all blanks. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70091

D70091

CERTIFICATE OF DEATH.

X 31

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Dobrocic. Donatyz.

(a) RESIDENCE NO. James Slater, Balto Md WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Dobrocic

6 DATE OF BIRTH (month, day, and year): June 14 1890.

7 AGE — Years: 32 — Months: 6 — Days: 1. — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, professioo or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 447

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Paul Donatyz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Annie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant (Address): John Grebiancka 475 S Paca St

15 Dec 15 1922, 19 Registrar: Robert F. Garrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): dec 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 19 22. to Dec 15, 19 22.

that I last saw h[illegible] alive on Dec 15, 19 22,

and that death occurred, on the date stated above, at X 30 m.

The CAUSE OF DEATH* was as follows:

Miliary T. B. (2)

(See note attached).

CONTRIBUTORY (Secoodary) (duration) yrs. mos. 2 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sym & Signs.

(Signed) A. J. Staroscic, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL 12/18 1922

20 UNDERTAKER: John Grebiancka — ADDRESS 475 S. Paca St

DEC 15 1922

N.B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

See Letter on File

12/15/22

Moore

Spec.—1-10-21 M&T 1500 Bks.

D70092

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70092

CERTIFICATE OF DEATH.

44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Jackson St. ST., 2nd WARD)

2-FULL NAME John Charles Goldhammer

(a) RESIDENCE No. 1406 Jackson St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 21 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or min.
	59	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broom Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Peter Goldhammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mr. Goldhammer (brother) 1406 Jackson

15 Filed ..... 19 ..... Registrar

Robert P. Marrazo.

Burial Permit Clerk.

DEC 15 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1922, to Dec 14, 1922, that I last saw h[illegible] alive on Dec 14, 1922, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) Unknown ds.

CONTRIBUTORY (Secondary) (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. T. Seabury, M. D.

12/15 19 (Address) 438 Fourth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL 12/16 1922

20 UNDERTAKER J. Frew McCully ADDRESS 130 E. Fort

B.—WRITE PLAINLY. AGE should be carefully supplied. Exact statement of age at last birthday is important. Information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70093

D70093

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1238 N Lombard ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth A Watts

(a) RESIDENCE NO. 1238 N Lombard ST., ... WARD 16.

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. 14 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edgar C. Watts

6 DATE OF BIRTH (month, day, and year) Dec. 1 - 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30.	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph A. Hebrank

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Ruth Hebrank

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Edgar C Watts (Address) 1238 N Lombard St

15 Record [illegible] Registrar

6 15 1922

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 16 1922

17 I HEREBY CERTIFY, That I attended deceased from 12. 1, 1922, to 12. 15. 1922

that I last saw her alive on 12. 14. 1922

and that death occurred, on the date stated above, at 11:25 P. m.

The CAUSE OF DEATH* was as follows:

Inflammation of Kidneys

(duration) yrs. 6 mos ds.

Pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) C. W. Watson, M. D.

, 19 (Address) 33 E Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Dec 18 1922

20 UNDERTAKER Lyn C Fulds — ADDRESS 1200 W Lombard

B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information may be properly classified. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information may be properly classified

Spec.—1-10-21—M&T—1500 Bks.

D.70094

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70094

CERTIFICATE OF DEATH.

90

REGISTERED NO. 60094

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Robbins

(a) RESIDENCE NO. 103 N Chapel St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newberg, N.C.

PARENTS

10 NAME OF FATHER Thomas Robbins

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Hester Bryington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Municipal Hospital Records. (Address)

15 DEC 5 1922, 19 Robert P. Harrison, Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 12 1922

17 I HEREBY CERTIFY, That I attended deceased from November 13 1922, to December 12 1922, that I last saw h... alive on December 12, 1922, and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency 6 (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Clyde McNeil, M. D.

12/12/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cemetery DATE OF BURIAL Dec 16 1922

20 UNDERTAKER Milton Davis ADDRESS 316 N Edn

NOTE.—WRITE PLAINLY. All items must be carefully supplied. AGE should be stated in years, months and days. Exact statement of occupation may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

See Letter attached ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70095

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70095

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 211 N. Eden St. (ST.) (WARD) 5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russel Martin (also known as Williams Russell)

(a) RESIDENCE. NO. 104 N. Bond St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr Miller

9 BIRTHPLACE (city or town) Fairfax Co
(State or country) Va.

PARENTS

10 NAME OF FATHER Sanford Martin

11 BIRTHPLACE OF FATHER (city or town) Fairfax Co. Va.
(State or country)

12 MAIDEN NAME OF MOTHER Ella Bowman

13 BIRTHPLACE OF MOTHER (city or town) Fairfax Co. Va.
(State or country)

14 Informant Ella Williams
(Address) 104 N. Bond St.

15 Filed 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/14/1922

17 I HEREBY CERTIFY, That I attended deceased from 12/12/1922 to 12/14/1922
that I last saw him alive on 12/ /1922
and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows: Pulmonary Hemorrhage.
over

Abscess 1½
(duration) ——— yrs. ——— mos. ——— ds.

CONTRIBUTORY (Secondary) Heart failure Hypostatic congestion
(duration) ——— yrs. ——— mos. ——— ds.

18 Where was disease contracted if not at place of death? 104 N. Bond St.

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Clifford Boyd M. D.

14/12/1922 (Address) 401 N. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 17 1922

20 UNDERTAKER Milton Davis

ADDRESS 315 N Eden St

C 15

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Pulmonary Tuberculosis

E. Mayfield Boyle, M.D.
423 N. Caroline Street
Baltimore, Md.

20 December 1922.

Dr C. Hampson Jones,
Health Department Annex,
Baltimore, Md.
Dear Sir,

I beg to say that the colored man, Russel Martin, who died on the 14th instant of pulmonary hemorrhage, was also known as Russel Williams.

I shall be very much obliged should this statement be made a part of the Death Record of the deceased.

Thanks.

Yours very truly,

E. Mayfield Boyle.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70096

D70096

CERTIFICATE OF DEATH.

90

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 E. 25 th ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William P. Foster

(Residence in Baltimore: No. 437 E. 25 th St.: 70 yrs., 5 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, July (Month) 31 (Day), 1851 (Year)

7-AGE, 71 yrs. 5 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Retired R.R. Engineer. (b) General nature of industry, business, or establishment in which employed (or employer): 30

9-BIRTHPLACE, (State or Country), Harford, Balto. Co., Md.

PARENTS.

10-NAME OF FATHER, Thos. P. Foster.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Co. Md.

12-MAIDEN NAME OF MOTHER Mary Ireland,

13-BIRTHPLACE OF MOTHER (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary J. Foster

(Address) 437 E. 25 St

15- Robert P. Harrison, Registrar.

Filed....., 191.....

15 1922 Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 15 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 26 1922, to Dec 15, 1922, that I saw him alive on Dec. 15, 1922, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rectal abscess & Pyelocystitis

(Duration) yrs. 14 mos. ds.

(Signed) Raugh Forsythe, M. D.

Dec 15, 1922. (Address) 421 E North Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, DEC 18 1922

20-UNDERTAKER Geo W Little — ADDRESS 2700 EDMONDSON AVE

N.B.—Every item of information must be given, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificate. Information is important.

Spec.—8-24-14—M. & T.—2000 Bks.

D70097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70097

CERTIFICATE OF DEATH.

REGISTERED NO. C 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3515 Forrest Park Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Katherine Schomburg

(Residence in Baltimore: No. 3515 Forrest Park Ave St.; 19 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, May (Month) 23 (Day), 1889 (Year)

7-AGE, 33 yrs. 6 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Centreville Md

PARENTS.

10-NAME OF FATHER, Clifford R. Dorrell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unity Aaron

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emil R. Schomburg

(Address) 3515 Forrest Park Ave

15- Robert P. Barraden, 191.....

157922 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 11 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1920, to 191..., that I saw her alive on Oct 15 1922, and that death occurred, on the date stated above, at 3.00 P.M.

The CAUSE OF DEATH* was as follows: Tuberculosis of Lungs

(Duration) 1 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Walter T. Denny M. D.

12-11-22 191... (Address) 315 Fauntleroy Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, Dec 15, 1922

20-UNDERTAKER John T. Denny — ADDRESS 115 Light St

N.B.—Every item of information must be properly classified. Each question must be answered so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70098

REGISTERED NO. 90 D70098

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1534 Hanover ST., 22 WARD)

2-FULL NAME. William Henry Meeske

(a) RESIDENCE NO. 1534 Hanover ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth S. Meeske

6 DATE OF BIRTH (month, day, and year) Oct 29 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	61	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto Tub Mill Baltimore Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frederick Meeske

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Eberhart

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Elizabeth S. Meeske (Address) 1534 Hanover St

15 Filed ....., 19..... Registrar

C 19927 Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11th, 1922, to Dec 13th, 1922, that I last saw him alive on Dec. 12th, 1922 and that death occurred, on the date stated above, at 12 10 P m.

The CAUSE OF DEATH* was as follows:

Acute Catarrhal Gastritis

42 Hours

CONTRIBUTORY (Secondary) Acute Myocarditis (duration) Immediate

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Kleibel M.D. 12/15, 1922 (Address) 1224 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Dec 16 1922

20 UNDERTAKER John F Denny

ADDRESS 715 Light

N. B. Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70099

D70099

74-001

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2809 Elsmada Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter T Willis

(a) RESIDENCE NO. 2809 Elsmada Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary S. Willis

6 DATE OF BIRTH (month, day, and year) Feb 12, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	55	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of Industry, business, or establishment in which employed (or employer) Sales

(c) Name of employer Roach + Willis

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER Wm Wallis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary S Willis

(Address) 2809 Elsmada Ave

15 Dated ..... 19 ..... Registrar

DEC 15 1922

Robert P. Carriger,

Chief Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 , 1922, to Dec 14 , 1922, that I last saw him alive on Dec 14 , 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic lung disorder +
Interstitial nephritis with
arteriosclerosis + hypertension

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J.F. Duncan M. D.

12/15 1922 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL Dec 16 1922

20 UNDERTAKER W J Tuckwell & Son ADDRESS Catherine

Be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D70100

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70100

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 Washington Blvd. ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Williamson

(a) RESIDENCE NO. 820 Washington Blvd. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Williamson

6 DATE OF BIRTH (month, day, and year): Feb. 22" 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer): 006

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Williamson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: June Oliver

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Mary Williamson
(Address): 820 Washington Blvd.

15 Filed Dec 15 1922 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 13" 19 22

17 I HEREBY CERTIFY, That I attended deceased from Apl. 19, 1922, to Dec 13th, 1922, that I last saw h~~e~~s alive on Dec 12, 1922, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Dis
& dropsy

(duration) not known yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Hardening of the arteries

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Assumption

(Signed) Ed Smith, M. D.

(Address) 1653 W. North Ave. 12/14 19 22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec 16" 1922

20 UNDERTAKER: Joseph L. B. Cook — ADDRESS: 1003 W. Baltimore St.

N. B.—WRITE PLAINLY, WITH CARBON. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This is very important.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D70101

CERTIFICATE OF DEATH

D70101

REGISTERED NO. C 33

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 520 Franklin Terrace 9 ST.; WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Joseph F. Illich (If not over 1 year, ... yrs. ... mos. ... ds.)

(Residence in Baltimore: No. 520 Franklin Terrace St. 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: August (Month) 9th (Day), 1875 (Year)

7 AGE: 47 yrs. 4 mos. 6 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Groceryman Self
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: James Illich

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Laura V. Illich

(Address) 520 Franklin Terrace

15. Robert P. Harrison, ... 191... REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dallo. Dec. 15. (Month) (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1922, to Dec. 15 1922, that I saw h~~im~~ alive on Dec 14, 1922, and that death occurred, on the date stated above, at 4. a. m.
The CAUSE OF DEATH* was as follows:

Gastro Intestinal Tuberculosis

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) ... (Duration) ... yrs. ... mos. ... ds.

(Signed), H. G. Ornstein M. D.

Dec. 15, 1922 (Address) 634 Gorsuch Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Druid Ridge — DATE OF BURIAL: Dec 18, 1922

20 UNDERTAKER: Lee Block — ADDRESS: 1038 Baltic St

A B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

51922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70102

CERTIFICATE OF DEATH.

45

D70102

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 Lake Ave. Govans ST., 27 WARD)

2-FULL NAME Jennie E. Baker

(a) RESIDENCE NO. 410 Lake Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Baker

6 DATE OF BIRTH (month, day, and year) Jan. 29" 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Hampshire

PARENTS

10 NAME OF FATHER John Moulton

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Hampshire

12 MAIDEN NAME OF MOTHER Eunice Abbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Hampshire

14 Informant Mary Baker Woodhull

(Address) 410 Lake Ave. Govans

15 Filed DEC 15 1922, 19 ... Registrar

Robert F. Carraher, Registrar of Records.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15" 19 22

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1922 to Dec. 15, 1922

that I last saw h[illegible] alive on Dec 14, 1922

and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines (colon)

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) T. H. Kellam M. D.

12/15, 19 22 (Address) 2757 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stewartstown Pa

DATE OF BURIAL Dec 17 1922

20 UNDERTAKER Jos B Cook

ADDRESS 1003 W Balto

N.B.—WRITE PLAINLY. AGE should be carefully supplied. Exact statement of DATE OF DEATH should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70103

D70103

CERTIFICATE OF DEATH.

X 127

REGISTERED NO. .....

1-PLACE OF DEATH St. Agnes Hosp

CITY OF BALTIMORE: (No. ..... ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Henry Flood

(a) RESIDENCE NO. Frederick Rd & Nunnery Lane ST. [redacted] WARD ....., Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Adalaide Selby

6 DATE OF BIRTH (month, day, and year) June 4th 1872

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
50	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Christina Norway

PARENTS

10 NAME OF FATHER Simon Flood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. H. H. Flood Frederick Rd. & Nunnery Lane

15 Filed ..... 19 ..... Registrar

151922

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-14- 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-13- ....., 1922, to 12-14 .1922.

that I last saw him alive on 12-14- .1922.

and that death occurred, on the date stated above, at 9 pm m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis -

3d hrs - (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of the Heart - (duration) yrs. mos. ds. Cerebral failure

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 12-14-22

Was there an autopsy? No -

What test confirmed diagnosis? Symptoms

(Signed) H. H. Caldwell M. D.

12/13 1922 (Address) St. Agnes Hosp -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Westfield DATE OF BURIAL Dec 6 1922

20 UNDERTAKER J. B. Cook ADDRESS 1003 Balto St

C. B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70104

1-001 D70104

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 13 WARD)

2-FULL NAME Emma P. Cook

(a) RESIDENCE NO. ~~Woodbury Md~~ 1513 Union Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 8-1909

7 AGE: Years 13 yrs; Months 3; Days 5; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Hubert M. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know Virginia

12 MAIDEN NAME OF MOTHER: Pearl E. Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " Balto. Co. Md

14 Informant: Hubert Cook (Address): Woodberry Md

15 Filed ..... 19 ..... Registrar

Robert P. Carriger, Burial Permit Clerk.

DEC 16 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1922, to Dec. 13, 1922, that I last saw her alive on Dec. 13, 1922, and that death occurred, on the date stated above, at 2 25 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

Intestinal Hemorrhage

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Laboratory test

(Signed) H. W. Harper, M. D.

19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Shrewsbury Pa.

DATE OF BURIAL: Dec. 17 1922

20 UNDERTAKER: Horace H. Burgee

ADDRESS: 3631 Hollins St.

13.—WRITE PLAINLY. All information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70105

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70105

CERTIFICATE OF DEATH.

134

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3635 Roland Ave ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis A. Younger

(a) RESIDENCE NO. 3635 Roland Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lydia Younger

6 DATE OF BIRTH (month, day, and year): Oct. 23-1854

7 AGE: Years 68 | Months 1 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Robt J. Younger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Pamela A. Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant (Address): Joseph Younger 3633 Roland Ave

15 Filed ..... 19 ..... Registrar

DEC 16 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922, to Dec 15, 1922, that I last saw h alive on Dec 14, 1922, and that death occurred, on the date stated above, at 6.35 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

12 h. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Interstitial Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Harry C. Algire M. D.

, 19 (Address) 1940 Rolandan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet

DATE OF BURIAL: Dec 18 1922

20 UNDERTAKER: Horace H. Burgee

ADDRESS: 3631 Falls Rd

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70106 D70106

CERTIFICATE OF DEATH.

8 129

REGISTERED NO.....

1-PLACE OF DEATH South Baltimore Hospital

CITY OF BALTIMORE: (No. 1211 Light ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert J. Fisher

(a) RESIDENCE NO. 1312 N Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Fisher

6 DATE OF BIRTH (month, day, and year): May 9 1876

7 AGE: Years 50 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seaford Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Albert Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Ida Fisher 1213 N. Gay St.

15 DEC 16 1922, 19 Robert F. Carrigan, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 14 1922

17 I HEREBY CERTIFY, That I attended deceased from November 30, 1922, to December 14, 1922, that I last saw him alive on December 14, 1922, and that death occurred, on the date stated above, at 8 00 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Embolism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Chr. Nephritis - Endocarditis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? -

What test confirmed diagnosis? ?

(Signed) John A. O'Connor M. D.

, 19 (Address) South Gold Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: DEC 16 1922

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E. Monument

B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be stated. Exact statement of information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70107 D70107

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 Homestead ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa Helwig

(Residence in Baltimore: No. 1521 Homestead St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	Widow

6-DATE OF BIRTH, December (Month) 11 (Day), 1834. (Year)

7-AGE, 88 yrs. mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Gatfried Thieme

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Christine Steike

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. William Brand

(Address) 1521 Homestead St

15-

Filed Dec 16 1922, 191 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 14 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 9 1922, to December 14 1922, that I saw h[illegible] alive on December 13 1922, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Heart Disease

(Duration) yrs. mos. 1 ds.

(Signed) H. Thomas Whitehead M. D.

December 14, 1922 (Address) 1818 Gorsuch ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, Dec. 16th, 1922.

20-UNDERTAKER George Schilling & Sons — ADDRESS 126 E Monument

N.B.—Every item of information should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70108

CERTIFICATE OF DEATH.

129 D70108

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 E Monument ST., 7 WARD)

2-FULL NAME Mary F. Schreiner

(a) RESIDENCE NO. 1501 E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of William F Schreiner

6 DATE OF BIRTH (month, day, and year) Sept 2nd 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dry goods Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Pickel

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Margaretta Kemp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr John H Pickel

(Address) 1611 E Fairmount ave

15 DEC 16 1922, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 14. 1922.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6 to Dec. 14, 1922.

that I last saw h Alive on Dec. 14 1922.

and that death occurred, on the date stated above, at 12.05 P m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

(duration) Acute 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What was confirmed diagnosis? Clinical

Signed Little M. A. Meyer, M. D.

19 22 (Address) 1032 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Dec 18th 1922

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument St

B.—WRITE PLAINLY with pen and ink. AGE should be carefully supplied. mation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70109

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D70109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 Twenty first St.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr William Burke

(a) RESIDENCE. No. 1618 E 25th ST., 8th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 4, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Patrick Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Burke
(Address) 1618 E 25th St.

15 Filed DEC 16 1922, 19 Robert F. Leutze
Special Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1922 to dec 13. 1922

that I last saw him alive on dec 12. 1922

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 0 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. A. Zimmerman, M. D.

Dec 13 1922 (Address) 2915 E Hoffman Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec. 16 1922

20 UNDERTAKER — ADDRESS

George F. Rutt — 1735 Harford Ave.

mation should be carefully supplied. Age should be
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70110

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70110

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Mosher ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna V. Downey

(a) RESIDENCE NO. 1124 Mosher ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Downey

6 DATE OF BIRTH (month, day, and year) June 29, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	76	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm N. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amanda M. Dell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Helen M. Jackson (Address) 1124 Mosher St

15 Dec 16 1922 Robert P. Griffith, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1922 to Dec 14, 1922

that I last saw her alive on Dec 14, 1922

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows: Organic Heart – Mitral Regurgitation.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirm diagnosis?

(Signed) Edwin Murray, M. D.

Dec 16, 1922 (Address) 1221 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Dec 16 1922

20 UNDERTAKER John A Mitchell — ADDRESS 1201 W. Fayette St

DEC 16 1922

N.B.—WHITE PAPER must be carefully supplied. AGE should be stated in every case. Information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. AGE should be stated in every case. Information should

(Ailanda C. Bosworth)

D70111

HEALTH DEPARTMENT—CITY OF BALTIMORE

81-001 D70111

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2424 Maryland Ave. ST.; 17 WARD)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ailanda C. Bosworth

(Residence in Baltimore: No. 2424 Maryland Ave St.; 26 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fe.

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Sept 2, (Month) (Day) 1868 (Year)

7-AGE: 54 yrs. 4 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE (State or Country): Carroll Co Md

PARENTS.

10-NAME OF FATHER: George Pickett

11-BIRTHPLACE OF FATHER (State or Country): Carroll Co Md

12-MAIDEN NAME OF MOTHER: Catherine Baile

13-BIRTHPLACE OF MOTHER (State or Country): Carroll Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. D. Bosworth

(Address) 1163 Cleveland ave

15-

Filed Dec 16 1922 Robert F. Harrison, Registrar.

Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec (Month) 14 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fall from stone Accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert F. Harrison M. D.
(Coroner.)

Dec 16, 1922 (Address) 2122 Roland ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL: Greenmount Cem. Ebenezer Church Cem. DATE OF BURIAL, Dec 17, 1922

20-UNDERTAKER: John C. Mitchell ADDRESS: 1201 W. Fayette St

D70112 HEALTH DEPARTMENT—CITY OF BALTIMORE D70112

CERTIFICATE OF DEATH.

4 / 181-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 766 W. Lexington St. St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Richard F. Winter

(Residence in Baltimore: No. 766 W. Lexington St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Dec (Month) 25 (Day) 1864 (Year)

7-AGE. 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto city

PARENTS.

10-NAME OF FATHER. John Winter

11-BIRTHPLACE OF FATHER, (State or Country). B. City Md

12-MAIDEN NAME OF MOTHER. Annie Zouck

13-BIRTHPLACE OF MOTHER, (State or Country). Balto city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H Winter

(Address) 737. Fayette st

DEC 16 1922 Robert P. Harrison

Filed 192.. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 15 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~Inquest, autopsy or inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating gas

(Duration) yrs. a few hours ds.

CONTRIBUTORY (Secondary) Probably Accidental

(Duration) yrs. mos. ds.

(Signed) H. K. Tomlinson M. D.
(Coroner.)

12-16 192.2 (Address) 117 N. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Windsor Md.	Dec 16 192.2
20-UNDERTAKER.	ADDRESS 1039
Chas F Wadmes	W. Pratt St

N. B.—Every item of information should be given, so that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Information is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70113 HEALTH DEPARTMENT—CITY OF BALTIMORE D70113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 565 Presstman St. 14 74-001 REGISTERED NO.

CITY OF BALTIMORE: (No. Thomas Nichols ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 565 Presstman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Rachel Nichols

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
76				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Talbott Co (State or country) Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Maria Skinner

13 BIRTHPLACE OF MOTHER (city or town) Talbott Co (State or country) Md.

14 Informant Fannie Wilson

(Address) 565 Presstman

15 Filed DEC 16 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1922, to Dec 15, 1922, that I last saw him alive on Dec 14, 1922 and that death occurred, on the date stated above, at 6.20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

12/15, 1922 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	12-18 1922
20 UNDERTAKER George H. Holland	ADDRESS 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Exact statement of DATE OF BIRTH and AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DATE OF BIRTH and AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160393 D70114

109-001 D70114

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lyason

(a) RESIDENCE No. 312 Lemmox Ave. Town ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Mrs. Lyanne Robinson 406 Myston St.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	3	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) (11)

(c) Name of employer (11)

9 BIRTHPLACE (city or town) (State or country) ? Maryland.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ?

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed DEC 16 1922, 19 Robert P. Barrack, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1922 to Dec 15 1922

that I last saw him alive on Dec 15 1922

and that death occurred, on the date stated above, at 10:?? A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage (post. tonsillectomy)

over

(overnight) (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) None. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Post-operative

Did an operation precede death? Yes Date of Dec. 14, 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Hemorrhage into tonsil

(Signed) John W. Baylor, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Rest Cem. DATE OF BURIAL 12-17 1922

20 UNDERTAKER George H. Holland ADDRESS 163 Druid Hill Ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. Exact statement of DISEASE or CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70115

D70115

CERTIFICATE OF DEATH.

REGISTERED NO. 33

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura adayer

(a) RESIDENCE NO. 5102 Biddle St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1916

7 AGE Years 6 Months Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) Don't know (State or country)

12 MAIDEN NAME OF MOTHER Bertha Ellis.

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant Mercy Hospital (Address) ~~Robert H. Gilkerson~~,

Filed DEC 16 1922 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1922, to Dec 14, 1922, that I last saw h[illegible] alive on Dec 14, 1922, and that death occurred, on the date stated above, at 11.20 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis. (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Cachexia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 22-22

Was there an autopsy? No

What test confirmed diagnosis? Operation findings

(Signed) W. J. Sheaggard M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL Dec 16 1922

20 UNDERTAKER Daniel Easton ADDRESS 916 Park ave

B.—WRITE PLAINLY. Exact statement of OCC... AGE should be carefully supplied. ...ay be properly classified. ...mation should be in plain terms, so that it may be ...ck of certificates. CAUSE OF DEATH ... See instructions on back of ... TION is very important.

D70116

D70116

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 845 Franklin ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Jenkins

(a) RESIDENCE. NO. 845 Franklin ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or WIFE of)~~ wife of Leon Jenkins

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Wm Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary Lilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Daniel Easton

(Address) 916 Pacific

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 1922, to Dec 15, 1922

that I last saw her alive on Dec 15, 1922

and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) exhaustion

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam

(Signed) David E. Grant, M. D.

(Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Dec 18 1922
20 UNDERTAKER	ADDRESS 916

8.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D70117

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70117

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 518 Welcome Alley. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Henson. (C)

10 ---------

(Residence in Baltimore: No. 518 Welcome Alley. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	Colored.	Widow.

6-DATE OF BIRTH. Do not know. (Month) ..... 1..... (Day) (Year)

7-AGE. 56 yrs. ---------- mos. ---------- ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). A. A. Co. Md.

PARENTS.

10-NAME OF FATHER. Samuel Murray. (C)

11-BIRTHPLACE OF FATHER. (State or Country). A. A. Co. Md.

12-MAIDEN NAME OF MOTHER. Sophia. -------(C)

13-BIRTHPLACE OF MOTHER. (State or Country). A. A. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Henson. (C) son.

(Address) 518 Welcome Alley.

15- DEC 16 1922 Robert P. Carrison, 192 Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 12th. 1922., 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) H. Outt Rinehardt (Coroner.)

Dec. 13th 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Robinson Station	Dec 16 1922
20-UNDERTAKER. A. A. Co. Ind.	ADDRESS 917
Daniel Easton	Pa ave

NOTE.—Every item of information should be given, and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70118

CERTIFICATE OF DEATH.

101-00 D70118

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3021 E Baltimore ST., 1 WARD)

2-FULL NAME George N. Allwell

(a) RESIDENCE NO. 3021 E Balto. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura Allwell

6 DATE OF BIRTH (month, day, and year): Dec. 14 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mail-Carrier

(b) General nature of industry, business, or establishment in which employed (or employer): U. S. Govern't

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Allwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Laura Allwell

(Address): 3021 E. Balto.

15 Filed , 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 13th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec., 3 , 1922, to Dec 14 , 1922, that I last saw him alive on Dec., 13, , 1922, and that death occurred, on the date stated above, at 12 M m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Allen C Beecham, M. D.

12-15, 1922 (Address) Allen Beecham 313 E Baltimore 15

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Dec 16th 1922

20 UNDERTAKER: J. A. Moran — ADDRESS 3000 E Baltimore

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This is very important.

D70119

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

D70119

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 133 c Ausgauth ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann Kirwan

(Residence in Baltimore: No. 133 c Ausgauth St., St.; 50 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Apr. (Month) 6 (Day), 1850 (Year)

7-AGE: 72 yrs. 8 mos. 9 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): England

PARENTS

10-NAME OF FATHER: James Finnigan

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Mary Hannon

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ward

(Address) 133 c Ausgauth St

15- Robert P. Harrison,

Filed ....., 191..... REGISTRAR

Burial Permit Issued

N.B.—Every item of information should be carefully supplied. Any answer to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 16 1922

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: December (Month) 15 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1922, to, Dec. 15 1922, that I saw h[er] alive on Dec. 14 1922, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ..... yrs ..... mos. 14 ds.

Contributory (SECONDARY) Dilatation of Heart

Myocarditis (Duration) ..... yrs ..... mos. 10 ds.

(Signed), Eli J. Bouchelle M. D.

Dec. 15 1922 [Address] 210 E. Fayette St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Cathedral

DATE OF BURIAL: Dec 15 1922

20-UNDERTAKER: H. C. Wedefeld

ADDRESS: 114 Fremont Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70120

CERTIFICATE OF DEATH.

16 1-00 D70120

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Williams

(a) RESIDENCE NO. ..... Glenburnie, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Dec 14, 1922

7 AGE Years ..... Months ..... Days ..... If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Milton Williams

11 BIRTHPLACE OF FATHER (city or town) Glenburnie (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cally Dodson

13 BIRTHPLACE OF MOTHER (city or town) Glenburnie (State or country) Maryland

14 Informant Callie Dodson (Address) Glenburnie, Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1922, to Dec 14, 1922, that I last saw her alive on Dec 14, 1922, and that death occurred, on the date stated above, at 2.35 P. m.

The CAUSE OF DEATH* was as follows: Premature

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Anthony V. Bucheuer, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. .....

DATE OF BURIAL 19

20 UNDERTAKER .....

ADDRESS .....

JOHNS HOPKINS HOSPITAL

Dec 14 1922

Robert E. Lee Register

(Commissioner of Health)

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be properly classified. Exact statement of occupation should be carefully supplied. AGE should be properly classified. Exact statement of occupation should be carefully supplied. AGE should be properly classified. Exact statement of occupation

D70121 HEALTH DEPARTMENT—CITY OF BALTIMORE D70121

CERTIFICATE OF DEATH. 27480

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 457 Lanvale St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Ann Boston

(Residence in Baltimore: No. 457 Lanvale St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Black	Widow

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1 ..... (Year)

7-AGE.	If LESS than 1 day.
78 yrs. ..... mos. ..... ds.	..... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ht Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Howard Dodson

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Rachel Dodson

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Henson

(Address) 457 Lanvale Ave

15- Robert F. Duffy, 192 ..... Registrar.
Oct 18 1922 Assistant Deputy Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 13 (Day) 192? (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemiplegia left side

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Wall M. D.
(Coroner)

12-16 192? (Address) 508 E Fort Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Zion Cemetery Baltimore	Dec 16, 1922
20-UNDERTAKER,	ADDRESS
Mrs. A. C. Elliott	Westminster

C. B.—Every item of information should be carefully supplied. Examine it that it may be properly classified. Exact statement state CAUSE OF DEATH in plain terms, so that it may be properly classified. is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70122

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70122

162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Baltimore, Md ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda Mabel Mooney

(a) RESIDENCE NO. 415 E. Lynn St. ST., WARD Baltimore Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-15-22

7 AGE	Years	Months	Days	If LESS than 1 day, 15 hrs. or min.
	—	—	X	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Agnes Hosp.
(State or country)

PARENTS

10 NAME OF FATHER Albert Mooney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Carrie Bozell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant
(Address) 415 E Lynn St

15 Filed DEC 16 1922, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-16-22 19

17

I HEREBY CERTIFY, That I attended deceased from 12-15-22, 19, to 12-16-22, 19,

that I last saw her alive on 12-16-22, 19,

and that death occurred, on the date stated above, at 8 P.M. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from nose following Anemia of Pregnancy of Mother & Prenatal uterine infecta (duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Caldwell, M. D.

19 (Address) St. Agnes Hospe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Dec 16 19 22

20 UNDERTAKER L. B. Hufford

ADDRESS 2216 Frederick Ave

NOTE.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

70123 D70123

HEALTH DEPARTMENT—CITY OF BALTIMORE

70123 D70123

CERTIFICATE OF DEATH.

99-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138. N. Chapel ST., 6 WARD)

2-FULL NAME Maria. A. Knoerlein

(a) RESIDENCE NO. 138 N. Chapel ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Knoerlein

6 DATE OF BIRTH (month, day, and year) Jan. 3. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80.	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown Brem.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER M. Brehm.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. R. Knoerlein. (Address) 138 N. Chapel St.

15 ROBERT R. KRAUTER, Registrar

DEC 17 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/14/1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 14, 1922, that I last saw h[illegible] alive on Dec 14, 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

(a) Senile Bronchitis

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. Allen Dixon, M. D.

, 19 (Address) 1131 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery. DATE OF BURIAL Dec 18 1922

20 UNDERTAKER George J. Rueth ADDRESS 1115 Harford Ave

N. B.—WRITE PLAINLY, WITH INK. ALL questions must be answered. AGE should be stated in every case. Exact statement of DATE of birth should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION is necessary, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

160287 D70124 7424

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7 202 D70124

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Heckerman

(a) RESIDENCE NO. 3 N. Wolfe St City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Entire mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Heckerman

6 DATE OF BIRTH (month, day, and year) Sept. 23, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Leonard Heckerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Heisterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed DEC 17 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1922.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 13 , 1922 , to Dec. 15 , 1922.

that I last saw him alive on Dec. 15 , 1922 ,

and that death occurred, on the date stated above, at 10.25 A m.,

The CAUSE OF DEATH* was as follows:

Broncho pneumonia left lower lobe and rt. lower lobe.

Myocardial weakness

(duration) yrs. mos 24 hrs.

CONTRIBUTORY (Secondary) Infection left hand

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? Date of Dec 13"

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) J. E. Reichert , M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thorncliffe Long Island DATE OF BURIAL Dec 16" 1922

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Gallo St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in years. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

70125 D70125

CERTIFICATE OF DEATH.

90 D70125

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1840 Hanover ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Metzdorf

(a) RESIDENCE. NO. 1840 Hanover ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Metzdorf

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Floyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Peter Metzdorf

(Address) 1840 Hanover St.

15 Filed DEC 17 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1922, to Dec 10, 1922, that I last saw h alive on Dec 10, 1922, and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) W. R. Campbell M. D.

Dec 10, 1922 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Dec 12th 1922
20 UNDERTAKER	ADDRESS
Leo G. Cook	Northern Parkway and ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. Exact statement of occupation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D70126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 70126

CERTIFICATE OF DEATH.

X 57

D70126

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Maryland General Hospital ST., WARD)

2-FULL NAME Hyt M. Cameron

(a) RESIDENCE NO. Rising Sun Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Cameron

6 DATE OF BIRTH (month, day, and year) Dec 15-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	70			

8 OCCUPATION OF DECEASED Farmer

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cecil Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Deceased

11 BIRTHPLACE OF FATHER (city or town) Cecil Co Md.
(State or country)

12 MAIDEN NAME OF MOTHER Martha Thompson

13 BIRTHPLACE OF MOTHER (city or town) Cecil Co Md
(State or country)

14 Informant Robt. L. Cameron
(Address) Rising Sun Md.

15 Filed DEC 17 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17- 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1922, to Dec 17, 1922,

that I last saw h[illegible] alive on Dec 17, 1922,

and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Gangrene (Right Foot)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home Nov 25

Did an operation precede death? Yes Date of Dec 11.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jesse Hubert Alleman, M. D.

19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rising Sun Md.

DATE OF BURIAL 12/18 1922

20 UNDERTAKER W J Tatnall & Sons.

ADDRESS Rising Sun Md.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D70127

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D70127

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 15 WARD)

2-FULL NAME Dorothy See Cook

(a) RESIDENCE NO. 2204 Chelsea Terrace ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 9 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 8 1906

7 AGE — Years: 16 Months: 9 Days: 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wm C Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Marian V. Punnchen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 DEC 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1922; to Dec 15, 1922, that I last saw h alive on Dec 15, 1922, and that death occurred, on the date stated above, at 8.50 P m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Chemical tests.

(Signed) [illegible], M. D.

12-15 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park DATE OF BURIAL DEC 18 1922

20 UNDERTAKER Geo W Little ADDRESS 2700 Edmondson Ave

N. B.—WHITE paper should be used. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATION is very important

D70128

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70128

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 836 N. Carey St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Frank Smith

(Residence in Baltimore: No. 836 N. Carey St., St.; yrs.....mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word) married

6-DATE OF BIRTH, Feb. 28, 1874 (Month) (Day) (Year)

7-AGE, 48 yrs. 10 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... 940

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, Wilder Smith

11-BIRTHPLACE OF FATHER, (State or Country), Va

12-MAIDEN NAME OF MOTHER, Fannie Taylor

13-BIRTHPLACE OF MOTHER, (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Thomas

(Address) 307 N. Dunstan

15-

Filed DEC 17 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 13, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) .....yrs.....mos. 1 ds.

CONTRIBUTORY (Secondary) no history.

(Duration) .....yrs.....mos.....ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Dec. 15 1922 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Va

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mt. Olivet Cemetery, Maryland. DATE OF BURIAL, 12/16 1922

20-UNDERTAKER, Co. Va. Frank Hensley. ADDRESS 528 N. Eddle

N. B.—Every item of information should be given, so that it may be properly classified. Exact information is very important. See instructions on back of certificate.

D70129

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70129

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH Md. Gen. Hosp.

City of BALTIMORE: (No. ~~1447 Myrtle Ave.~~ 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John G. Curtis 28

(Residence in Baltimore: No. 1147 Myrtle Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word) married

6-DATE OF BIRTH. about 1880
(Month) (Day) (Year)

7-AGE. 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work machinist
(b) General nature of Industry, business, or establishment in which employed (or employer) (automobiles)

9-BIRTHPLACE, (State or Country). Talbot Co, Md

PARENTS.

10-NAME OF FATHER, Major Curtis

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Elizabeth Howell

13-BIRTHPLACE OF MOTHER, (State or Country) Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Curtis

(Address) 1147 Myrtle Ave.

15- DEC 17 1922 ROBERT R. KRAUTER, Registrar.
Filed Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 13, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) no history.

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Dec. 15 1922. (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, 12/18 1922

20-UNDERTAKER, James D. Hennessy ADDRESS 828 N. Bdle

N. B.—Every item of information should be properly classified. Each item should be plain terms, so that it may be properly classified. Each state CAUSE OF DEATH in plain terms, so that it may be properly classified. Each is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70130

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70130

CERTIFICATE OF DEATH.

44

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore Md

CITY OF BALTIMORE: (No. 2844 Parkwood ST., 13 WARD)

2-FULL NAME Minnie Adler

(a) RESIDENCE No. 2844 Parkwood ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. MEDICAL CERTIFICATE OF DEATH is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Adler

6 DATE OF BIRTH (month, day, and year): Jan 15, 1888

7 AGE: Years 34 Months 11 Days ..... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Albert Sinskey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sarah Caplan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Meyer Sinskey

(Address) 1629 W. North Ave

15 Filed DEC 17 1922, 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 15 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to December 15, 1922, that I last saw him alive on Dec 15, 1922, and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Oct 20, 1922

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Operation

(Signed) Johannes Clark, M. D.

19 (Address) 2031 Parkwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arbor Friendship

DATE OF BURIAL: Dec 17 1922

20 UNDERTAKER: Fact Lewis

ADDRESS: 1729 E Oliver

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70131

CERTIFICATE OF DEATH.

90

D70131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2706 Boston ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Knapik

(a) RESIDENCE NO. 2706 Boston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. 0 mos. 0 ds.

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated in years, months and days. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Knapik

6 DATE OF BIRTH (month, day, and year) Apr. 19-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Thomas Knapik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Lak.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Carrie Knapik

(Address) 2706 Boston Ave

15 DEC 17 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1922, to Dec. 14, 1922, that I last saw him alive on Dec. 14, 1922, and that death occurred, on the date stated above, at 2 45 a.m.

The CAUSE OF DEATH* was as follows:

Aortic and mitral insufficiency

Mitral stenosis

Cardiac decompensation

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Acute pulmonary oedema

(duration) yrs. mos. 4 hrs ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Lab.

(Signed) Fred A. Rees, M. D.

12/16, 1922 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary.

DATE OF BURIAL 12/18 1922

UNDERTAKER William F. Gallagher

ADDRESS 618 Eastern Ave.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70132

CERTIFICATE OF DEATH.

38

D70132

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1614 W. Mulberry ST., 19 WARD)

2-FULL NAME George Thomas Parran

(a) RESIDENCE NO. 1614 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept, 8, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	24	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Calvert Co. (State or country) Maryland.

10 NAME OF FATHER Joseph Parran

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Idella Janes

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co. (State or country) Maryland.

14 Informant Idella Parran (Address) Calvert Co. Maryland

15 Filed DEC 17 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec, 16, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec, 14, 1922, to Dec, 16, 1922, that I last saw him alive on Dec, 15, 1922, and that death occurred, on the date stated above, at 6 a, m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis and Myocarditis

(duration) 1 yrs. mos ds. (from birth)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no —

What test confirmed diagnosis? —

(Signed) David Frankel M. D.

12/16 1922 (Address) 122 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brooks Church Cemetery Calvert Co. Md.	Dec 17 1922
20 UNDERTAKER	ADDRESS
N. S. Brown & Son	W. Mulberry St

N. B.—Information should be carefully supplied. AGE among other things, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lucile

Spec.—1-10-21—M&T—1500 Bks.

D70133

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D70133

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 E. Chase ST., 7 WARD)

2-FULL NAME John L. French

(a) RESIDENCE NO. 1903 E Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Jan 16th 1920

7 AGE: Years 2 Months 11 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John B. French

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Kath E. French

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: John B. French (Address) 1903 E. Chase St.

15 Filed DEC 17 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 16th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1922, to Dec 16, 1922, that I last saw h[illegible] alive on Dec 16, 1922, and that death occurred, on the date stated above, at 4. P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac Dilation,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Spence, M. D.

Dec 16 (Address) 1680 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem — DATE OF BURIAL: Dec 17 1922

20 UNDERTAKER: Geo M. Smith Son — ADDRESS: 811 N Wolfe

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be given. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70134 D70134

CERTIFICATE OF DEATH.

90 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1406 E Fayette St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W Kayle

(Residence in Baltimore: No. 1406 E Fayette St.; 73 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Widower

6-DATE OF BIRTH. Unknown (Month) ..... (Day) ..... 184[illegible] (Year)

7-AGE. 73 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Rooming House
(b) General nature of industry, business, or establishment in which employed (or employer). Keeper 86

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, John D. Kayle

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Wagner

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. H. Stymmler

(Address) Belvedere Apts

DEC 17 1922 ROBERT R. KRAUTER,

Filed ..... 192.... Registrar. Burial Permit Clerk

N. B.—Every item of information should be given, so that it may be proper state CAUSE OF DEATH in plain terms, so that it may be properly classified. is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 12 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cyanosis — Due to Carbon monoxide poisoning by leaking gas stove, (over 24 hrs.)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Probably Organic

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Adams M. D.
(Coroner.)

12-16 1922 (Address) 5 W. E. Fayette

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Westerly Cem. Louisville Ky

DATE OF BURIAL. Dec 19th 1922

20-UNDERTAKER. John F. Downes & Son

ADDRESS 901 Hollins St.

Per F. Howard

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70135

REGISTERED NO. D70135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 Tramore Rd Ward 21)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Ehmling

(a) RESIDENCE NO. 212 Tramore Rd Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ehmling

6 DATE OF BIRTH (month, day, and year) May 10, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	63	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired 8 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Augusta Ehmling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Righter

13 BIRTHPLACE OF MOTHER (city or town) Hanover (State or country) Germany

14 Informant Mrs Walter Jones (Address) 212 Tramore Ave

15 DEC 17 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1922, to Dec. 16, 1922, that I last saw him alive on Dec 12, 1922, and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1543 Homestead St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. S. Parsons, M. D.

Dec 17, 1922 (Address) Glen Hills.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 12/18 22

20 UNDERTAKER Wm Pickuer Sons

ADDRESS North Pa

N. B.—WRITE plainly. AGE should be carefully supplied. Exact statement of DISEASE and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70136

CERTIFICATE OF DEATH.

43

D70136

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 722 W. Barre ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Clinton

(a) RESIDENCE NO. 722 W. Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Clinton (nee Burns)

6 DATE OF BIRTH (month, day, and year) April 30-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Ship Yard Balto,

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Mrs. Mary E. Clinton

(Address) 722 W. Barre st

15 Filed DEC 17 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 1922

17 I HEREBY CERTIFY, That I attended deceased from July 13 1922 to Dec 13th 1922

that I last saw him alive on Dec. 13th 1922

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of buccal cavity (base of tongue)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Harry Goldman M. D.

19 (Address) 1816 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Ass. Co.

DATE OF BURIAL Dec 18 1922

20 UNDERTAKER James Dignan & Son

ADDRESS 1000 S. Broadway

N. B.—WHITE paper should be carefully supplied. AGE should be properly classified. Exact statement of Occupation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D70137

REGISTERED NO. D70137

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 547 W. Hamburg ST., 21 WARD)

2-FULL NAME Mary E. Davis

(a) RESIDENCE NO. 547 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of William B. Davis

6 DATE OF BIRTH (month, day, and year) Sept. 4 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Chesapeake City

(State or country) Cecil Co. Md

PARENTS

10 NAME OF FATHER William Groves

11 BIRTHPLACE OF FATHER (city or town) Washington D.C.

(State or country)

12 MAIDEN NAME OF MOTHER Margaret Dougherty

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant William B. Davis

(Address) 547 W. Hamburg St.

15 FILED DEC 17 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1922

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to Dec 16, 1922,

that I last saw her alive on Dec 14, 1922, and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

Status

(duration) 5 yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 14 1922

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Pathological

(Signed) Samuel L. Kelly, M. D.

12/16, 1922 (Address) 332 S. Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

20 UNDERTAKER James Dignan & Son

DATE OF BURIAL Dec 18 1922

ADDRESS 1000 S. Paca St

N. B.—WRITE PLAINLY, WITH INK. All items must be supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be properly classified. Exact statement of OCCUPATION should be stated. Information should be properly classified. Exact statement of OCCUPATION should be stated. Information should be properly classified

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70138

CERTIFICATE OF DEATH.

49 D70138

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2454 W. Baltimore ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Gillin

(Residence in Baltimore: No. 2454 W. Baltimore St.; 71 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Nov 10, 1851 (Month) (Day) (Year)

7-AGE, 71 yrs. 1 mos. 5 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James Rial

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Corbett

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Alice Bernheimer

(Address) 2454 W. Baltimore

15- Filed DEC 17 1922, 191.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH December 15, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1921, to Dec 15 1922, that I saw h[illegible] alive on Dec 13 1922, and that death occurred, on the date stated above, at 3.45 A m.

The CAUSE OF DEATH* was as follows:

(a) Acute Pancreatitis
(b) Spinal Caries
(c)

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm A Egan M. D.

Dec 18, 1922 (Address) 101 N. Eden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral DATE OF BURIAL, Dec 18, 1922

20-UNDERTAKER William Cook ADDRESS 502 E North ave

N. B.—Every item of information should be carefully supplied. Exact statement of occupation and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

D70139

HEALTH DEPARTMENT--CITY OF BALTIMORE

D70139

CERTIFICATE OF DEATH

129 REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3354 Strickland ST.; 70 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Jane Lee

(Residence in Baltimore: No. 3354 Strickland St.: 6 yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 STATE WHETHER SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6 DATE OF BIRTH Nov (Month) 24 (Day) 1846 (Year)

7 AGE 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Pyle

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hester Lancaster

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Lee

(Address) 3354 Strickland

15 DEC 17 1922 Filed 191

ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 16 (Month) (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Six years ago, 191 , to Dec 16 1922, that I saw her alive on Dec 16 , 1922, and that death occurred, on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Not Known (Duration) yrs. mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Mary L. Ingram M. D.

Dec 16, 1922 (Address) 2439 N Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. In the ..... ds. State ..... yrs. ..... mos. ..... ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Deer Creek Md

DATE OF BURIAL Dec 18 ,191

20 UNDERTAKER Wm Cook

ADDRESS 502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70140

CERTIFICATE OF DEATH.

66 D70140 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1007 Madison Ave, St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carroll L. Weaver

(Residence in Baltimore: No. 1007 Madison ave. St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Aug (Month) 8 (Day) 1889 (Year)

7-AGE: 33 yrs. 4 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Brown Lunt Candy Co.

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Robt J Ward

11-BIRTHPLACE OF FATHER, (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Ada B. Totty

13-BIRTHPLACE OF MOTHER, (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elizabeth M. Weaver
(Address) 1007 Madison Ave

15-DEC 17 1922 ROBERT R. KRAUTER, Registrar.
Filed ..... 192.... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 16 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute alcoholism

(Duration) ....yrs. ....mos. 1/4 ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Dec. 16, 1922 (Address) 1532 Edmondson Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral DATE OF BURIAL, 12/19 19 22

20-UNDERTAKER, Wm Cook ADDRESS 502 E Hoth

N. B.—Every item of information should be given in plain terms, so that it may be properly classified. Each state CAUSE OF DEATH in plain terms, so that it may be properly classified. Each is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70141

100-001

D70141

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mary Dorothy ST., Stevens WARD)

2-FULL NAME 1747 E. Lafayette

(a) RESIDENCE NO. 1747 - E. Lafayette WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry W. Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia

12 MAIDEN NAME OF MOTHER Mary D. Ducey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Mass

14 Informant Harry Stevens (Address) 1747 E. Lafayette

15 Filed DEC 17 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-16-1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1922, to Dec 15, 1922, that I last saw h[illegible] alive on Dec 15, 1922, and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchio Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hartmann M. D.

12/16, 1922 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Hanford Rd DATE OF BURIAL Dec 18 1922

20 UNDERTAKER Wm Cook ADDRESS 502 E Nath

N. B.—Whatever is written should be carefully supplied. AGE should be properly classified. Exact statement of DECEASED'S mation should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70142 36 D70142

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 708 Euson St

CITY OF BALTIMORE: (No Christs Institution Hospital ST., WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Fassnelli

(a) RESIDENCE No. 20 So. Chester St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced. (write the word): Sngl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 15 | Months: | Days: | If LESS than 1 day, hrs. or ntin.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt Md

PARENTS

10 NAME OF FATHER: Joseph Fassnelli

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rosa Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Mrs. Fassnelli 20 So Chester St

15 Filed DEC 17 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 16 1922

17 I HEREBY CERTIFY, That I attended deceased from December 14, 1922 to December 16, 1922 that I last saw him alive on December 16, 1922 and that death occurred, on the date stated above, at 12. Noon

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Peritonitis + Complications disease (duration) yrs. 3 mos. 2 ds.

18 Where was disease contracted if not at place of death? 20 So. Chester St

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. L. W. Kennagh M. D.

12-16 1922 (Address) 708 Euson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer | DATE OF BURIAL: Dec 18 1922

20 UNDERTAKER: Enoch Grace & Son | ADDRESS: 1105 Eden

N. B.—WRITE plainly. All information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. ATTENDING PHYSICIAN'S SIGNATURE is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tuberculosis of the Bone of Leg.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70143

D70143

CERTIFICATE OF DEATH. 123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #401-Woodlawn Road. ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CHARLES WILLMS.

(a) RESIDENCE NO. 401-Woodlawn-Road. ST., 27 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 50 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Willms.

6 DATE OF BIRTH (month, day, and year) July-4-1848.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired from the

(b) General nature of industry, business, or establishment in which employed (or employer) firm of Willms Co.

(c) Name of employer surgical instruments.

9 BIRTHPLACE (city or town) Cologne
(State or country) Germany

PARENTS

10 NAME OF FATHER Herman Willms

11 BIRTHPLACE OF FATHER (city or town) Cologne
(State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Schrotte

13 BIRTHPLACE OF MOTHER (city or town) Cologne
(State or country) Germany

14 Informant Miss Julia Willms (daughter)
(Address) 401-Woodlawn-Road, City.

15 Filed DEC 17 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 19 22, to Dec 17, 19 22,

that I last saw h— alive on Dec 16, 19 22

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Cholecystitis; Cholelithiasis

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Pneumonia in addition

(duration) yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Dec 17, 19 22 (Address) 1013 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
DRUID RIDGE CEMETERY	DEC-20-22
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, with ink. All items must be carefully supplied. AGE should be stated in years, months and days. If less than one day, hours or minutes. Information should be carefully supplied. AGE should be stated in years, months and days. If less than one day, hours or minutes. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70144

REGISTERED NO. D70144

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #1016-Bennett-Place. ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME WILLIAM HIRST DENNIS.

(a) RESIDENCE NO. #1016-Bennett-Place. ST., 18 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 7 mos. 23 ds. How long in U. S., if of foreign birth? 61 yrs. 7 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Josephine Gorsuch Dennis.

6 DATE OF BIRTH (month, day, and year) April-22-1861.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	61	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Floor Manager.

(b) General nature of industry, business, or establishment in which employed (or employer) Department Store.

(c) Name of employer Joel Gutman and Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew T. Dennis.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Jane Martin.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Mrs. Josephine G. Dennis (wife)
(Address) 1016-Bennett-Place, City.

15 Filed DEC 17 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1921, to Dec 15, 1922,

that I last saw him alive on Dec 16, 1922

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) W. E. Krumbhaar, M. D.

12/16, 1922 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL WESTERN CEMETERY. DATE OF BURIAL Dec-18-22

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. All information should be carefully supplied. AGE should be stated in years, months and days, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70145 (90) D70145

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) 3001-Abell-Av. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Elder Maguire

(a) RESIDENCE NO. 3001-Abell-Av. ST., 12 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 2 mos. 11 ds. How long in U. S., if of foreign birth? 80 yrs. 2 mns. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Farley Maguire

6 DATE OF BIRTH (month, day, and year) Oct-3-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	80	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired from Balto. P.O.

(b) General nature of Industry, business, or establishment in which employed (or employer) Post-Office Dep't.

(c) Name of employer U.S.Government.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James L. Maguire

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susanna Savage

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Chas T. Byrnes (daughter)
(Address) 3001-Abell-Av., City.

15 Filed DEC 17 1922 19 ROBERT A. KNAUTER, Registrar
Rachel Porter, Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-14- 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 29. 1922. to Dec 14. 1922.
that I last saw him alive on Dec 14. 1922
and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Obstruction of Heart

(duration) 3 mos ds.

CONTRIBUTORY (Secondary) Senile

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Consultation

(Signed) H. H. Pearce, M. D.

Dec 17 1922 (Address) 2105 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Dec-18-22

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE

N. B.—WRITE PLAINLY, with ink. All questions should be answered. Information should be carefully supplied. AGE should be stated in every case. CAUSE OF DEATH in plain terms, so that it may be properly classified. ...ement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70146

CERTIFICATE OF DEATH.

10 D70146

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 42 Rosemont Ave ST., Lauraville WARD)

2-FULL NAME Dorothy Peitemeyer

(a) RESIDENCE NO. 42 Rosemont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 10/23/1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	5	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph Peitemeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Cora West

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Joseph Peitemeyer (Address) 42 Rosemont Ave

15 DEC 17 1922 ROBERT R. KNAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1922, to Dec 16, 1922, that I last saw h[illegible] alive on Dec 15, 1922 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) — yrs. — mos 21 ds.

CONTRIBUTORY (Secondary) Diptheria

(duration) — yrs. — mos. 17 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Morris B. Green, M. D.

(Address) Hamilton Baltimore Md. 12/17 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery. DATE OF BURIAL Dec. 18 1922

20 UNDERTAKER Geo. F. Ruth. ADDRESS 1735 Harford Ave.

N. B.—WRITE PLAINLY, with ink. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully classified

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

103 D70147

D70147

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 E. Eager ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Tulley

(a) RESIDENCE NO. 1822 E. Eager ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of Sarah E. Tulley

6 DATE OF BIRTH (month, day, and year) Feb 16, 1841

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or ....min.
81	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigarmaker

(b) General nature of Industry, business, or establishment in which employed (or employer): 117

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Aquilla Tulley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Love

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Maggie Hanson (Address) 1820 E. Eager

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar

DEC 17 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1922, to Dec, 1922, that I last saw him alive on December 16, 1922, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Senility and Congestion of Lungs

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Congestion of Lungs

(duration) ..... yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death? ~ ~ ~ ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) Thomas J. Simms M. D.

19 (Address) 1026 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: Dec 19 1922

20 UNDERTAKER: Zurhorst & Zurhorst

ADDRESS 1739 Eager

N. B.—WRITE PLAINLY. AGE should be carefully supplied. Exact statement of information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. Exact statement of information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70148

D70148

101-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 W. Hughes ST., 22 WARD)

2-FULL NAME Joseph Roberts

(a) RESIDENCE NO. 102 W. Hughes ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 10 mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	10	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER James Roberts

11 BIRTHPLACE OF FATHER (city or town) Greensville Co (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ella Bordley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant James Roberts (Address) 102 W. Hughes St

15 Filed DEC 18 1922 ROBERT P. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1922, to Dec. 15, 1922, that I last saw him alive on Dec. 14, 1922, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia.

(duration) — yrs. — mos. 2-1 ds.

CONTRIBUTORY (Secondary) (duration) .. yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) David Frankenberg, M. D.

12/15, 1922 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodbrun DATE OF BURIAL Dec 18 1922

20 UNDERTAKER J. L. Brown ADDRESS Towson Md

N. B.—WRITE PLAINLY. Exact statement of facts must be carefully supplied. AGE should be properly classified. Information should be carefully supplied, so that it may be properly classified. AGE should be properly classified. Exact statement of facts must be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D70149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70149

Dr Hazlehurst
3722 Eastern Ave.

CERTIFICATE OF DEATH.

REGISTERED NO. 131

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 S. Rose ST., 1 WARD)

2-FULL NAME Julia Mayafski

(a) RESIDENCE NO. 712 S. Rose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Gustava A. Mayafski

6 DATE OF BIRTH (month, day, and year) Oct 26 1876

7 AGE: Years 46 | Months 1 | Days 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Gajewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gustava Mayafski

(Address) 712 S. Rose St.

15 Filed DEC 18 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1922, to Dec 12, 1922, that I last saw h[illegible] alive on Dec 12, 1922, and that death occurred, on the date stated above, at 3 30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Franklin Hazlehurst, M. D.

, 19 (Address) 3722 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cemetery — DATE OF BURIAL: Dec 18 1922

20 UNDERTAKER: A. Sander & Sons — ADDRESS: 710 Fleet St

N. B.—WRITE PLAINLY. All items must be supplied. AGE should be stated correctly. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied

Spec.—1-10-21—M&T—1500 Bks.

D70150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70150

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 S Streeper ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalene Hoff.

(a) RESIDENCE NO. 510 S. Streeper ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Henry Hoff.

6 DATE OF BIRTH (month, day, and year) July 6 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Trageserser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs Catherine Donenman 510 S. Streeper St.

15 Filed DEC 18 1922 19 ..... Registrar ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1922

17 I HEREBY CERTIFY, That I attended deceased from July ..., 1921, to Dec 15 ..., 1922, that I last saw h. alive on Dec 15 ..., 1920, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac (Valvular dis) Senile —

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. L. Jones, M. D.

, 19 (Address) 125 E. Eutaw —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL Dec 18 1922

20 UNDERTAKER H. Sander & Sons

ADDRESS 1710 Fleet St.

N. B.—WRITE PLAINLY, with ink. All items should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D70151

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117

D70151

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 6 WARD)

2-FULL NAME Barnard Auer

(a) RESIDENCE NO. 104 N. East St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be accurately stated. Exact statement of occupation and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. MEDICAL CERTIFICATE is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Olive Auer

6 DATE OF BIRTH (month, day, and year) Oct 12, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 170

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Miller Bros.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Auer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Olive Auer (Address) 104 North East ave

15 Filed DEC 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1922, to Dec 16, 1922, that I last saw him alive on Dec 16, 1922, and that death occurred, on the date stated above, at 2.20 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Ruptured Appendix

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 12/6/22

Was there an autopsy? no

What test confirmed diagnosis? Gen. Examination

(Signed) H. C. Marino, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Dec 18 1922

20 UNDERTAKER H. Lander Sons

ADDRESS 1710 Eutaw St

Colacee.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70152

D70152

CERTIFICATE OF DEATH. 23

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Lombard ST.: 4 WARD) University Hospital

2-FULL NAME Andrew Colacee.

(a) RESIDENCE. NO. 527 W. Lexington ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Raphael Colacee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Raffa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hospital Records
(Address)

15 Filed DEC 18 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/15 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/15, 1922, to 12/15, 1922, that I last saw him alive on 12/15, 1922, and that death occurred, on the date stated above, at 11P m.

The CAUSE OF DEATH* was as follows:
Epidemic Encephalitis.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Leon Fredrow, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec 18 19

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1521 W. Lombard St

N. B.—Information should be carefully supplied. All blanks should be properly classified. Exact statement of occupation may be of great importance, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70153

CERTIFICATE OF DEATH.

74-001 D70153

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 722 N. Mount ST.: 16 WARD)

2-FULL NAME William B. Ridgley

(a) RESIDENCE. NO. 722 N. Mount ST., WARD.

(Usual place of nbode) (If nonresident give city or town nnd State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Henrietta Ridgley

6 DATE OF BIRTH (month, day, nnd year) Nov. 21 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Egmen & ice business

(b) General nature of industry, business, or establishment in which employed (or employer) light hauling & ice sold

(c) Name of employer N/A

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Samuel Ridgley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D. C.

12 MAIDEN NAME OF MOTHER Fanny Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City Md

14 Informant (Address) Harriett Ridgley 722 N. Mount St

15 Filed DEC 7 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 - 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26 - , 1922, to Dec. 15 - , 1922, that I last saw h[illegible] alive on Dec. 15 - , 1922, and that death occurred, on the date stated above, at 6-15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) - yrs. - mos. 2 ds.

CONTRIBUTORY (Secondary) Hepatic congest & Gastritis

(duration) - yrs. - mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys. & Symptoms

(Signed) Thos. L. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Dec 18 19 22

20 UNDERTAKER David Easton

ADDRESS Pa ave

N. B.—[illegible] should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D70154

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70154

CERTIFICATE OF DEATH.

141

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Murray.

(a) RESIDENCE NO. 400 W. Lafayette St. ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. Murray.

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework,

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant (Address) David Easton 916 5th ave

15 Filed DEC 18 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1922, to Dec 16, 1922, that I last saw h[illegible] alive on Dec 16, 1922, and that death occurred, on the date stated above, at 12:40 P m.

The CAUSE OF DEATH* was as follows:

Incarcerated Uterus

(duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes. Date of Dec 7, 1922

Was there an autopsy? No.

What test confirmed diagnosis? Operation & Clinical findings

(Signed) L. H. Wissig M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL DEC 19 1922

20 UNDERTAKER David Easton

ADDRESS 916 5th ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70155

CERTIFICATE OF DEATH.

89 D70155

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 E. 20th ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank R. Eldridge

(a) RESIDENCE NO. 408 E. 20th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed.

6 DATE OF BIRTH (month, day, and year) Oct 2nd 1850.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Eldridge.

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey.

12 MAIDEN NAME OF MOTHER Emeline Darling.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York.

14 Informant Violet B. Eldridge. (Address) 408 E. 20th St.

15 Date Received DEC 18 1922

ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 15th, 1922, to Dec 15th, 1922, that I last saw him alive on Dec 15th, 1922, and that death occurred, on the date stated above, at 9 30 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ~ 2.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) Wm Elliott Mitchell, M. D.

12/18 1922 (Address) 2006 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Dec 18 1922

20 UNDERTAKER John O Mitchell

ADDRESS 1201 N. Fayette St.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70156

CERTIFICATE OF DEATH.

185 2

Registered No. D70156

1-PLACE OF DEATH

City of BALTIMORE: (No. 1104 Leadenhall Street. St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Hutton. 75 ---------- .

(Residence in Baltimore: No. 1104 Leadenhall St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	White.	Divorced.

6-DATE OF BIRTH. Do not know. 1.....
(Month) (Day) (Year)

7-AGE. 75 yrs. --- mos. --- ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Produce dealer.
(b) General nature of industry, business, or establishment in which employed (or employer): in market. 045

9-BIRTHPLACE. (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Henry Reineker.

11-BIRTHPLACE OF FATHER. (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Mary Schulz.

13-BIRTHPLACE OF MOTHER. (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Larkin. (daughter).

(Address) 517 E. Clement St.

DEC 18 1922 ROBERT R. KRAUTER,
Filed..... 192 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 14th, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental fall. November 18th, 1922.
Lobar Pneumonia.
(Duration) ---- yrs. --- mos. 6 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto K. Einhardt M. D.
(Coroner)

Dec 17, 192 2. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cem. DATE OF BURIAL. Dec 18, 1922

20-UNDERTAKER. Margaret I. Flynn ADDRESS 1422 Light St.

N. B.—Every item of information should be carefully and properly classified. Exact statements are required. To state CAUSE OF DEATH in plain terms, so that it may be properly classified, is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 ltks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

52 D70157

D70157

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 E Preston St.; V WARD)

2-FULL NAME Vivian Cohen

(a) RESIDENCE. No. 2029 E Preston St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Sol Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Nathan Tziganoff

(Address) 2029 E Preston St

15 Filed DEC 18 1922 ROBERT R. KRAUTER, Register Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1922, to Dec. 17, 1922, that I last saw her alive on Dec. 17, 1922, and that death occurred, on the date stated above, at 5 30 ~~P~~ m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Bayless, M. D.

12/18, 1922 (Address) 210 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Sholom Cem	Dec 19 1922
20 UNDERTAKER Hay Jenkins	ADDRESS 412 E Balto St

N. B.—Information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be understood, is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D70158 D70158

CERTIFICATE OF DEATH

90 Registered No. C .....

1 PLACE OF DEATH

City of Baltimore (No. 2 4 N. Pulaski St. 70 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Miss Elizabeth Weaver

(Residence in Baltimore: No. 2 4 N. Pulaski St.; 10 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wht.

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Sept. (Month) 13, (Day) 1840 (Year)

7 AGE: 82 yrs. 3 mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): 69

9 BIRTHPLACE (State or country): Balto.

PARENTS

10 NAME OF FATHER: John Weaver

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaretha Fel

13 BIRTHPLACE OF MOTHER (State or country): Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Homer F. Elliott

(Address) 24 N. Pulaski St

15 Filed DEC 18 1922 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 12 (Month) 15 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1922, to Dec. 15 1922, that I saw her alive on Dec. 15, 1922, and that death occurred, on the date stated above, at 8:45 a. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease
(Aortic insufficiency)

(Duration) 10 yrs. — mos. — ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. M. Stevenson M. D.

12/17, 1922 (Address) 2730 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Balto Cemetery

DATE OF BURIAL: Dec 18, 1922

20 UNDERTAKER: George C. Schwab

ADDRESS: 1101 Druid Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Borges

D70159

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70159

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3706 Chatham Rd. 15 90 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline Borges

(Residence in Baltimore: No. 3706 Chatham Rd. St.; yrs. 54 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

6-DATE OF BIRTH, Jan. 7 (Month) (Day) 1858 (Year)

7-AGE, 64 yrs. 11 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Home Duties (b) General nature of industry, business, or establishment in which employed (or employer) 03

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Henry Meisler

11-BIRTHPLACE OF FATHER, (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Catherine Gross

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. C. Wiesemann

(Address) 3706 Chatham Rd

15- Filed DEC 18 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 14, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. ds.

(Signed) J. J. Heuisler M. D. (Coroner.)

Dec. 17 1922 (Address) 2727 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery DATE OF BURIAL. Dec 19th 1922

20-UNDERTAKER. George Schilling & Sons ADDRESS 1126 E Monument

N. B.—Every item of information should be carefully ... be properly classified. Exact statement of ... state CAUSE OF DEATH in plain terms, so that it may be ... is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70160

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70160

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2047 Division ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Ross

(a) RESIDENCE. NO. 2047 Division ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jennie H. Ross

6 DATE OF BIRTH (month, day, and year) Oct. 12-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward 070

(b) General nature of industry, business, or establishment in which employed (or employer) Steamship Co.

(c) Name of employer Chesapeake Steamship Co.

9 BIRTHPLACE (city or town) (State or country) D. C.

PARENTS

10 NAME OF FATHER Richard B. Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) D. C.

12 MAIDEN NAME OF MOTHER Mary Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D. C.

14 Informant (Address) Jennie H. Ross 2047 Division Street

15 Filed DEC 18 1922 19 ROBERT F. KRAMER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24 1922 to Dec. 15 1922

that I last saw him alive on Dec. 14 1922

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis + Cardiac Asthma

(duration) yrs. 1 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms.

(Signed) W. V. Carr M. D.

Dec 15 1922 (Address) 515 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Dec. 18 1922
20 UNDERTAKER Jno. M. Johnson	ADDRESS 1234 Etting St.

N. B.—All information should be carefully supplied. AGE should be accurately stated. Exact statement of DISEASE or CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001 D70161

D70161

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 534 N. Robinson ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Rebecca Clark

(a) RESIDENCE. NO. 534 N Robinson ST., 7 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs — mos — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm H. Clark

6 DATE OF BIRTH (month, day, and year) July 29. 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	3	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Pierson Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Maria Davies

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Errol R. Clark
(Address) 534 N. Robinson St

15 Filed DEC 18 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 16th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 9th 1922, to Dec. 16th, 1922, that I last saw her alive on Dec. 16th 1922, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robt. S. Kirk M. D.

12/20, 1922 (Address) 3126 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Dec 18 1922
20 UNDERTAKER	ADDRESS
Thos. Francis Carter	1004 Lanvale

CAUSE OF DEATH to be plainly written. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70162

CERTIFICATE OF DEATH.

100-001 D70162

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 2830 Riggs Ave (St.) 16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen V. Leyhe

(a) RESIDENCE NO. 2830 Riggs Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3, 1920

7 AGE — Years: 2 — Months: 5 — Days: 15 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. H. Leyhe

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen R. Bosfield

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Wm. H. Leyhe (Address) 2830 Riggs

15 Filed DEC 18 1922 ROBERT R. KNAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1922 to Dec 17, 1922

that I last saw her alive on Dec 17, 1922

and that death occurred, on the date stated above, at 1A m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) J. H. Burley M. D.

Dec 19 22 (Address) 1128 Poplar Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Dec 20 1922

20 UNDERTAKER: Robert L. Little — ADDRESS: 2 Edmondson

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Oliver

D70163 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 74-001 D70163

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 537 McMechen ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Louise Oliver

(Residence in Baltimore: No. 537 McMechen St.; ....yrs., ...mos. ....ds.)

N.B.—Every item of information should be given as accurately as possible. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 2 (Month) 1879 (Day) , 1 (Year)

7-AGE, 63 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Domestic
(b) General nature of industry, business, or establishment in which employed (or employer). Home

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Geo. Washington

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Maria Washington

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ellis Anderson

(Address) 537 McMechen St.

15- Filed DEC 16 1922 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 15th (Month) (Day) , 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10th 1922, to Dec 15th 1922, that I saw h[illegible] alive on Dec 13th 1922, and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

Broncho

(Duration) ....yrs. 7 mos. 15 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ....yrs. 7 mos. ....ds.

(Signed) A. Lee Ellis M. D.

Dec 16, 1922 (Address) 722 Mosher

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn

DATE OF BURIAL, Dec 18, 1922

20-UNDERTAKER Clarence Burgh

ADDRESS 1364 Maney St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70164 D70164

CERTIFICATE OF DEATH. 161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Barclay ST., 17 WARD)

2-FULL NAME. Anna Elizabeth Smith

(a) RESIDENCE NO. 1604 Barclay ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 8 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Edward B. Smith

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Colorado

12 MAIDEN NAME OF MOTHER Helen E. Clark

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Evelyn L. Smith
(Address) 1604 Barclay

15 DEC 18 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1922, to Dec 16, 1922.

that I last saw her alive on Dec 15 1922

and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
about 7 months

(duration) ..... yrs. ..... mos 8 ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward J. Lovell M. D.

12/17, 1922 (Address) 413 Wendover Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity. DATE OF BURIAL Dec 18 1922

20 UNDERTAKER W. A. Cook ADDRESS 605 E Fayette

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70165

D70165

44

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 938 N. Chester St ST.: 7 WARD)

2-FULL NAME Adolph Caspar Helmbold

(a) RESIDENCE. No. 938 N. Chester ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Augusta Helmbold

6 DATE OF BIRTH (month, day, and year) Aug 28 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
64	64	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Tan Hides

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Helmbold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna E Leimbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Elise A Helmbold 938 N. Chester St.

15 Filed DEC 16 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1922

17 I HEREBY CERTIFY, That I attended deceased from October 6, 1922, to Dec-15-, 1922, that I last saw him alive on Dec-13-, 1922, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D J Herzog MD M. D.

Dec 15, 1922 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 18th 1922
20 UNDERTAKER Robt J Turner & Son	ADDRESS 1442 N Broadway

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70166

902

D70166

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 S. Bentalou ST., 20 WARD)

2-FULL NAME Eva Charlotte Nuessle

(a) RESIDENCE NO. 403 S. Bentalou ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. = mos. 16 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob F. Nuessle

6 DATE OF BIRTH (month, day, and year): Feb 20 = 1850

7 AGE: Years "72" | Months = | Days 16 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife 07
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (City or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Brandel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Charlotte E. Nuessle 403 S Bentalou

15 Filed DEC 18 1922, 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 15, 1922, that I last saw her alive on Dec 14, 1922, and that death occurred, on the date stated above, at 1 30 a. m.

The CAUSE OF DEATH* was as follows:
Endocarditis.
Arteriosclerosis.

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema.
(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert C. Fetsch M. D.

12/17 1922 (Address) 2151 Shelburne Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: Dec 18 1922

20 UNDERTAKER: F. B. Wagner

ADDRESS: 2236 Fleet Ave

D70167

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70167

CERTIFICATE OF DEATH.

160-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adelaide Tolbert

(Residence in Baltimore: No. 100 N. Eden St.; yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Female	Black	Single

6-DATE OF BIRTH. Sept ..... 1909.
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
13 yrs. 2 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School
(b) General nature of industry, business, or establishment in which employed (or employer). School

9-BIRTHPLACE. (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Thomas L Tolbert

11-BIRTHPLACE OF FATHER. (State or Country). Va

12-MAIDEN NAME OF MOTHER. Louise Jackson

13-BIRTHPLACE OF MOTHER. (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas L Tolbert

(Address) 100 N Eden St

Filed DEC 18 1922 192.

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 15 192.2
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Probably Lobular)
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) 2 yrs. mos. ds.

(Signed) J. H. Falkenau M. D.
(Coroner.)

12-18 192.2 (Address) 505 E Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Midland Va	Dec 18 1922

20-UNDERTAKER.	ADDRESS
John W Henderson	Emmorent

N. B.—Every item of information should be carefully considered, and exact statement of facts should be given. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Isidore L. Carberry

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70168

CERTIFICATE OF DEATH.

100-002 D70168

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 Ettring ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isadore Leslie Carberry

(a) RESIDENCE. NO. 1806 Ettring ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 30 - 22

7 AGE: Years — Months 7 — Days 17 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Andrew Carberry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rachel Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Andrew Carberry 1806 Ettring St.

Filed DEC 18 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1922, to Dec 17, 1922, that I last saw h alive on Dec 17, 1922, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Dr. J. Kaufer M. D.

, 19 (Address) 2008 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cemetery	Dec. 19 1922
20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill

N. B.—While all items of information should be carefully supplied. AGE should be stated accurately. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70169

CERTIFICATE OF DEATH.

90

D70169

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1844 N. Durham ST., 8 WARD)

2-FULL NAME John Haelmann

(a) RESIDENCE No. 1844 N. Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Melonia Heilmann

6 DATE OF BIRTH (month, day, and year) Aug 20 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John H Heilmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Melonia Heilmann (Address) 1844 N. Durham St

15 Filed DEC 4 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 20 1922, to Dec 17 1922, that I last saw him alive on Dec 16 1922, and that death occurred, on the date stated above, at 10.4 m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward D Lowe, M. D.

, 19 (Address) 1 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Dec. 19 1922
20 UNDERTAKER Frank A. Finke	ADDRESS 915 N. Gay St.

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D70170

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 403 So. Washington St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Diddlemeyer

(Residence in Baltimore: No. 403 So. Washington St.; 4 yrs., 11 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Dec (Month) 29th (Day) 1917 (Year)

7-AGE. 4 yrs. 11 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. Jacob Diddlemeyer

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Sophia Trackawiak

13-BIRTHPLACE OF MOTHER. (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophia Diddlemeyer

(Address) 403 So. Washington St.

15 Filed DEC 18 1922 19.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 17th (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) 4 yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) ~

(Duration) — yrs. — mos. — ds.

(Signed) Thos. B. Horton M. D.
Coroner.

Dec 17th 1922 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Rosary Cemetery	Dec. 19 1922.
20-UNDERTAKER. M. J. Sadowski.	ADDRESS 905 S. Ann St.

N. B.—Every item of information should be carefully supplied. Exact statement of occupation should be given, so that it may be properly classified. Exact statement of cause of death in plain terms, so that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D70171

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D70171

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 N. Lombard St ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helena E. Hisky,

(Residence in Baltimore: No. 1115 N. Lombard St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid.

6-DATE OF BIRTH. Feb. 12, 1831
(Month) (Day) (Year)

7-AGE. 91 yrs. 10 mos. 5 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER. James Haley,

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER. Mrs. Cunningham,

13-BIRTHPLACE OF MOTHER (State or Country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Hisky

(Address) 1115 N Lombard

15- Filed DEC 18 1922 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 15, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 15, 1922, that I saw h[illegible] alive on Dec 15, 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos Dorsey, M. D.

12/18/22, 1922 (Address) 886 N Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount

DATE OF BURIAL, Dec 20, 1922.

20-UNDERTAKER, John Field

ADDRESS 1208 W Lombard

N. B.—Every item of information should be carefully supplied, Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70172

D70172

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 S Calvert ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David C Lewis

(a) RESIDENCE. NO. 114 S Calvert ST.: 18 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Lewis

6 DATE OF BIRTH (month, day, and year) .....

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron worker

(b) General nature of industry, business, or establishment in which employed (or employer) Raymond Bartlett

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas A Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Julia .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mary E Lewis

(Address) 114 S Calvert

Filed DEC 18 1922 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 13 1922 to Dec 16 1922

that I last saw him alive on Dec 16 1922

and that death occurred, on the date stated above, at 4 20 p m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) 4 yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Arthritis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at work

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Signs

(Signed) Jos E Muse, M. D.

Dec 16, 1922 (Address) 1520 Hollins Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL Dec 20 1922

ADDRESS .....

20 UNDERTAKER John J Fields 1200 W Lombard

N. B.—WHITE PLAINLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

D70173

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70173

CERTIFICATE OF DEATH.

Registered No. C 179

1-PLACE OF DEATH

City of BALTIMORE: (No. Bayview Hospital St., 18 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Murray

(Residence in Baltimore: No. 336 N. Fremont Ave St.; 72 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

6-DATE OF BIRTH. Unknown 1850
(Month) (Day) (Year)

7-AGE. 72 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. house work
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Magherty

(Address) 336 N Fremont Ave

15- Filed DEC 18 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 15th 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

1st = & 3rd = Degree burns on body R. arm & R Hip

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

Clothing accidently caught fire from a Coal oil stove

(Signed) Thos. B. Horton M. D.
(Coroner)

Dec 18th 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cem. DATE OF BURIAL. Dec 19th 1922

20-UNDERTAKER. for Jos. Cowan & Son per J. F. Cowan ADDRESS 701 Hallum St

N. B.—Every item of information should be carefully supplied. Exact statement of cause CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70174

CERTIFICATE OF DEATH.

16-003 D70174

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 146 N. Lakewood ST., 6 WARD)

2-FULL NAME Benjamin F. Seebold

(a) RESIDENCE NO. 146 N. Lakewood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. — mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Betty Seebold

6 DATE OF BIRTH (month, day, and year) Nov 21/46

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sht of 086

(b) General nature of industry, business, or establishment in which employed (or employer) Packing Hse

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry J. C. Seebold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Mary A.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Betty Seebold

(Address) 146 ~~NEXT OF KIN~~

15 DEC 18 1922 Filed Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1922, to Dec 15, 1922, that I last saw him alive on Dec 15, 1922, and that death occurred, on the date stated above, at 8 50 P. m.

The CAUSE OF DEATH* was as follows: Pernicious Anemia

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Chronic Tapeworm

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Chas L Taylor, M. D.

12-17-1922 (Address) 1264 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 12/18 1922

ADDRESS 2016 Orleans

20 UNDERTAKER Philip Herwig

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—1-10-21—M&T—1500 Bks.

D70175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70175

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 152 Homestead ST., 9 WARD)

2-FULL NAME Felix F. Campbell

(a) RESIDENCE NO. 152 Homestead ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, with ordinary pen and ink. AGE should be stated in every case. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie M. Campbell

6 DATE OF BIRTH (month, day, and year) Aug. 13, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	68	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber Maker

(b) General nature of industry, business, or establishment in which employed (or employer) C. 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Bernard Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Cassidy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Hattie M. Campbell

(Address) 152 Homestead St.

15 DEC 18 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 15th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 9th, 1922, to Dec 15th, 1922.

that I last saw h alive on Dec 15th, 1922.

and that death occurred, on the date stated above, at 12 Pm.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Osteosarcoma

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Harry Longwell M. D.

12/15/22 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Dec 19 1922

20 UNDERTAKER H. C. Wiedefeld — ADDRESS 914 Greenmt Ave.

Spec.—1-10-21—M&T—1500 Blks.

D70176

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70176

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 1 WARD)

2-FULL NAME Louise Kiefer

(a) RESIDENCE NO. 1097 S. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	73	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Gunther

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records (Address)

15 Filed DEC 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1922

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1922 to Dec. 17, 1922, that I last saw her alive on December 17, 1922, and that death occurred, on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage (duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Mitchell M. D.

12/18/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL John Lawn Cemetery

DATE OF BURIAL Dec 20, 1922

20 UNDERTAKER John Schmidt

ADDRESS 2008 Eden

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

D70177

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70177

CERTIFICATE OF DEATH.

129

REGISTERED No. C

1-PLACE OF DEATH (No. 241 N. Gilmor St.; WARD 4)
CITY OF BALTIMORE (No. 241 N. Gilmor St.; WARD 4)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar F. M. Spies

(Residence in Baltimore: No. 241 N. Gilmor St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, ... (Month) ..... (Day) 1856 (Year)

7-AGE, 66 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Clerk 39

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles F. Spies

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar F. Spies

(Address) 4708 Park Heights

15- Filed 1922, 191.... Robert F. Harrison, Registrar.

Burial Permit Oliver

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 17, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebro Arterial Sclerosis

(Duration) ..... yrs. Sudden mos. ..... ds.

(Signed) James W. Swanborn M. D.
(Coroner.)

Dec. 17, 1922 (Address) 700 Cleveland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, 12/19, 1922

20-UNDERTAKER Wellman Bros — ADDRESS 502 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70178

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70178

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rawley C. Kaiss

(a) RESIDENCE NO. 1203 Edmondson ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Kaiss

6 DATE OF BIRTH (month, day, and year) Dec 23 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44 45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 009

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Kaiss

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Christina Schultz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Hospital Records

(Address) M. C. H.

15 Filed , 19 Robert P. Harriss, Registrar

Burial Permit Issued.

DEC 18 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 15 1922

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1919, to Dec. 15, 1922, that I last saw him alive on Dec. 15, 1922, and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Manic depressive psychosis (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Padaglucca M. D.

19 12-15-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 12/19/22

20 UNDERTAKER W. P. Cook

ADDRESS 502 E Wash

NB.—WRITE PLAINLY, WITH CHARCOAL. AGE should be stated EXACTLY. If information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70179

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70179

CERTIFICATE OF DEATH.

51

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., 4 WARD)

2-FULL NAME Sadie Battaglia

(a) RESIDENCE NO. 313 W. Pearl St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27-17

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
X	5	X	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Samuel Battaglia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Sarah.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Samuel Battaglia

(Address) 313 Pearl St

Filed DEC 19 1922, 19... F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17, 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1922. to Dec. 17, 1922.

that I last saw her alive on Dec. 27, 1922

and that death occurred, on the date stated above, at 8.15 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S & S.

(Signed) J. J. Krager, M. D.

, 19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bethesda Cemetery	Dec 19 1922
20 UNDERTAKER	ADDRESS
H M Routson	238 N Eut

DEC 18 1922

NOTE—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sep is. tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Rheumatic Fever

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70180

D70180

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 N. Bond St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Fowler

(Residence in Baltimore: No. 209 N. Bond St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Color

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, 10 (Month) 22 (Day), 1921 (Year)

7-AGE, 1 yrs. 1 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Augustus D Fowler

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Beulah Montford

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother

(Address) 209 N. Bond St

15- Oct 18 1922, Robert P. Garrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 17 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1922, to Oct 16 1922, that I saw h[illegible] alive on Oct 18th 1922, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Contributory to Retention of Urine 7 days.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Carey)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Crozat M. D.

Oct 17, 1922. (Address) 192 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dec 19 Burt Cemetery

DATE OF BURIAL, Dec 19, 1922

20-UNDERTAKER Edward Bryan

ADDRESS 631 N Eutaw

Every item of information should be carefully supplied. Exact statement of OCCUPATION is important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D70181

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70181

90

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2132 N. Calvert ST., 12 WARD)

2-FULL NAME Frederick Achilles Lucchesi

(a) RESIDENCE NO. 2132 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 0 mos. 24 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida I. Masson

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) 109

(c) Name of employer State Roads Commission

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Lucchesi

11 BIRTHPLACE OF FATHER (city or town) Luca

(State or country) Italy

12 MAIDEN NAME OF MOTHER Ellen Howe

13 BIRTHPLACE OF MOTHER (city or town) England

(State or country)

14 Informant (Address) Wm. F. Crimmins 2132 N. Calvert St.

15 Filed ..... 19..... Registrar

DEC 10 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1922

17 I HEREBY CERTIFY, That I attended deceased from 1920, 19..... to Dec 16, 1922.

that I last saw him alive on Dec 16, 1922.

and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis + Valvular Heart disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H K Gorman, M. D.

12/19 1922 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 12/19 1922

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

N. B.—WRITE PLAINLY, with ink. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70182 D70182

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 E North Ave WARD 9)

2-FULL NAME Martin Lyons

(a) RESIDENCE. No. 910 E North Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 69 yrs -- mos. -- ds.

N.B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Halpin

6 DATE OF BIRTH (month, day, and year) Oct. 12, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired - Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Brodie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs. Elizabeth Lyons 910 E. North Avenue

15 DEC 18 1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1922 to Dec 16, 1922 that I last saw h[illegible] alive on Dec 16, 1922 and that death occurred, on the date stated above, at 1 00 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia of left sides, due to Cerebral Hemorrhage

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jefferies Buell M. D.

12/18 1922 (Address) 2844 82 Danesh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	12/19 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

Spec.—1-10-21—M&T—1500 Blks.

D70183

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70183

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 7th WARD)

2-FULL NAME Eliza Johnson

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jim Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Municipal Hospital Records.

15 Robert P. Carlson, ..., 19 ..... Registrar

DEC 18 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 14 19 22

17 I HEREBY CERTIFY, That I attended deceased from December 4, 19 22, to December 14, 19 22,

that I last saw her alive on December 14, 19 22,

and that death occurred, on the date stated above, at 9 P.M. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X-ray

(Signed) Clyde A. Heuel, M. D.

12/15/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner of Health.

Per Wm. S. WOODALL

DEC 18 1922

WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be made. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70184 15/865

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70184

CERTIFICATE OF DEATH. X 135

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME Frank Martin

(a) RESIDENCE NO. Monogah, W. Va. ~~ST.~~ ~~WARD~~ W. Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 23 days ds. How long in U. S., if of foreign birth? yrs. mos. ds.

~~Unknown~~

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Martin

6 DATE OF BIRTH (month, day, and year) May 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	70	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocery

(b) General nature of industry, business, or establishment in which employed (or employer) " 086

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Nicolas Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy ?

12 MAIDEN NAME OF MOTHER Dark Knaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy ?

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 DEC 18 1922 ROBERT L. BATTLE, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 21, 1922 to Dec 18th 1922

that I last saw him alive on Dec 18th 1922

and that death occurred, on the date stated above, at 4:15 A. m.

The CAUSE OF DEATH* was as follows:

Benign prostatic hypertrophy

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Nov 28 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Franklin P. Johnson, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Park Va

DATE OF BURIAL Dec 18 1922

20 UNDERTAKER Joseph Abrams

ADDRESS 221 B Way

NTB.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT MUST BE TYPEWRITTEN OR PRINTED. PHYSICIAN'S SIGNATURE should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. TION is very important

Spec.—8-24-14—M. & T.—2000 Bks.

D70185

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70185

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 McHenry ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Estella Flowers

(Residence in Baltimore: No. 202 Laureville Balto City St.; ..... yrs., 6 mos. ..... ds.)

202 McHenry Ave

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.)
Fe	white	widow

6-DATE OF BIRTH, Dec (Month) 23 (Day) 1865 (Year)

7-AGE, 66 yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Mother
(b) General nature of industry, business, or establishment in which employed (or employer)..... Mother

9-BIRTHPLACE, (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, Skelton Price

11-BIRTHPLACE OF FATHER (State or Country), Balto Co Md

12-MAIDEN NAME OF MOTHER Eliz. Fishpaw

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Harry F Flowers

(Address) Lutherville Md

15-

Filed ..... Robert P. Harrison ..... Registrar.

DEC 18 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 17 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1922 to Dec 17 1922, that I saw h[illegible] alive on Dec 16 1922, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Diabetes 6 mos

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Chas Jones M. D.

Dec 17, 1922 (Address) 4702 Bellona Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Cedarwood Md

19-PLACE OF BURIAL OR REMOVAL, Loters Cemetery — DATE OF BURIAL, Dec 19, 1922

20-UNDERTAKER John Burns Sons — ADDRESS Towson Md

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is necessary. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is necessary. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D70186

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70186

CERTIFICATE OF DEATH.

57

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 S. Charles ST., 23 WARD)

2-FULL NAME Christian Chas. Oetter

(a) RESIDENCE NO. 1525 S. C Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 7 mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Oetter

6 DATE OF BIRTH (month, day, and year) April 26th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	66	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John Oetter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Mrs Mary E Zeuss
(Address) 1525 S. Charles

15 Filed ..... 19 ..... Robert T. Harrison, Registrar

DEC 18 1922

N.B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12.17.22

17 I HEREBY CERTIFY, That I attended deceased from 2.26.17, 19..., to 12.17.22, 19...,

that I last saw h in alive on 12.17.22, 19...,

and that death occurred, on the date stated above, at 4.35 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 8 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Philip S. Fowler M. D.

12 18, 22 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Conn — DATE OF BURIAL Dec 20 22

20 UNDERTAKER B Schlosser Son — ADDRESS 1037 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70187 D70187

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 303 Stemers alley (St.) 3 (Ward)

2-FULL NAME Anthony Annarelli

(a) RESIDENCE. No. 303 Stemers alley St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Steven Annarelli

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Adelina Cicalese

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Steven Annarelli
(Address) 303 Stemers alley

15 Filed Dec 18 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1922, to Dec 18, 1922, that I last saw h alive on Dec 18, 1922, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Congenital Weakness
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth
(duration) 2 wks yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent — DATE OF BURIAL: Dec 19 1922

20 UNDERTAKER: Mendelsohn & Gibson — ADDRESS: 3781 N

DEC 18 1922

MARGIN RESERVED FOR BINDING. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70188 D70188

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2417 Biddle ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kala

(a) RESIDENCE NO. 2417 Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Theresa

6 DATE OF BIRTH (month, day, and year) March 18 58

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	64	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self.

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Theresa Kala

(Address) 2417 E. Biddle.

15 Filed ..... 19 Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1922, to Dec 17, 1922, that I last saw h— alive on Dec 17, 1922, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Powers M. D.

Dec. 19 1922 (Address) 801 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	Dec. 20 1922
20 UNDERTAKER Wm Cook	ADDRESS 502 E. Fay. Ave

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 18 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70189

D70189

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 7 WARD)

2-FULL NAME David McComas

(a) RESIDENCE NO. 1712 E. Pratt St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 966

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co.,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Alex McComas

11 BIRTHPLACE OF FATHER (city or town) Harford Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Street

13 BIRTHPLACE OF MOTHER (city or town) Harford Co.
(State or country) Maryland

14 Informant Municipal Hospital Records.
(Address)

Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 19 22

17 I HEREBY CERTIFY, That I attended deceased from November 14 19 22, to December 17 19 22,

that I last saw him alive on December 17, 19 22,

and that death occurred, on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 1 yrs. mos ..... ds.

CONTRIBUTORY (Secondary) Auricular fibrillation (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Clyde McNeil M. D.

12/18/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. DATE OF BURIAL 12-20 1922

20 UNDERTAKER Wm. Cook ADDRESS 502 C. Road

DEC 18 1922

Robert P. Harries,
Burial Permit Clerk.

NOTICE—WRITE PLAINLY, WITH CARBON PENCIL. AGE should be stated EXACTLY. The information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Bks.

D70190

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70190

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3907 Forrest Park Ave ST. 45 WARD) 74-801

2-FULL NAME Robert John Kearney

(a) RESIDENCE NO. 3907 Forrest Park Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Paint 066

(c) Name of employer Hanline Bros

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Patrick V. Kearney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Donahue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Kearney Wright
(Address) 3907 Forrest Park Ave

15 Robert E. Barrett, ... 19 ..... Registrar

Burial Permit Clerk.

DEC 18 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct-13 1922, to Dec-18- 1922, that I last saw him alive on Dec-17 1922, and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Nephritis with High Blood Pressure and Hemiplegia (Left side). Oct-15-1922

(duration) yrs. 2 mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation and Failure (duration) — yrs. — mns. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Wesley Gale, M. D.

(Address) 720 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cem

DATE OF BURIAL Dec 20 19 22

20 UNDERTAKER Wm J Weikel & Sons

ADDRESS North & P

N.B.—WRITE PLAINLY, WITH INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Information should be in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21 M&T 1500 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70191

D70191

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 23 WARD)

2-FULL NAME Mary Williams

(a) RESIDENCE NO. 1005 Leadhall St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	-	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Municipal Hospital Records. (Address)

15 Filed ....., 19 ..... Registrar

DEC 19 1922

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. AGE should be stated EXACTLY. PHYSICIAN should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 17 19 22

17

I HEREBY CERTIFY, That I attended deceased from November 15, 19 22, to December 17 19 22,

that I last saw her alive on December 17, 1922,

and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic (myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Mckay M. D.

12/19/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion — DATE OF BURIAL: 12-20 1922

20 UNDERTAKER: Jno. H. Toadvine — ADDRESS 145 Walbrook

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70192

CERTIFICATE OF DEATH.

90 D70192

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5318 Dunmore Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew Griffith (Griffin).

(a) RESIDENCE. NO. 5318 Dunmore Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mah

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Griffin Mary Millum Griffin

6 DATE OF BIRTH (month, day, and year): July 21-1852

7 AGE: Years 70 Months 4 Days 23

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Patapsco Md.

PARENTS

10 NAME OF FATHER: Robert Griffin.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rosa Scougler.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Adele Weaver.
(Address): 5318 Dunmore Ave

15 Filed . 19 Registrar

DEC 19 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 16 1922.

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 16, 1922, that I last saw h— alive on Dec 16, 1922, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Mitral Valvular Heart Disease.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) J Ridlon Md, M. D.

12/19/22, 19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Woods Bethel Liberty Road

DATE OF BURIAL: 12/19 1922

20 UNDERTAKER: Samuel T Tennebey

ADDRESS 578 Biddle

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70193

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70193

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) German Aged Home ST.: Baltimore and Payson Sts (No.) 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henriette Lehr.

(a) RESIDENCE. No. German Aged Home ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 6 mos. ds. How long in U. S., If of foreign birth? 40 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Philip Jacob Lehr

6 DATE OF BIRTH (month, day, and year) Feb 16 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Heinrich Grosch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Richter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Keeper German Aged Home Baltimore and Payson St

15 Filed DEC 19 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk, Mary Joseph B. Cook

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 12 1922 to Dec 17 1922 that I last saw h alive on Dec 17 1922 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Hauff, M. D

Dec 19 1922 (Address) 1743 W Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec. 19" 1922
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Balto St

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70194

HEALTH DEPARTMENT—CITY OF BALTIMORE D70194

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 N. Washington ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Mary Kestler

(a) RESIDENCE NO. 1009 N. Washington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Kestler

6 DATE OF BIRTH (month, day, and year) August 23/1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer — 37

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Andrew Kestler. (Address) 1009 N. Washington St

Filed DEC 19 1922 19 ROBERT B. KNAUER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-17 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-1-22 19.. to 12-17 1922 that I last saw her alive on 12-16 1922 and that death occurred, on the date stated above, at 8:35 A m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation Endocarditis Hypertension

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Fred Ruppersberger, M. D.

12-17, 1922 (Address) 1009 N. Washington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Dec. 20 1922

20 UNDERTAKER George J. Ruth

ADDRESS 1235 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S ENTRIES should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D70195

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70195

90

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 3 WARD)

2-FULL NAME John McGraw

(a) RESIDENCE NO. 1524 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	45	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry McGraw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Eugenia Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Municipal Hospital Records.

(Address) ROBERT R. KRAUTER,

Filed DEC 19 1922 19 Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1922

17 I HEREBY CERTIFY, That I attended deceased from November 21, 1922, to December 17 1922, that I last saw him alive on December 17, 1922, and that death occurred, on the date stated above, at 2:50 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Mckenzie M. D.

12/19/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Dec 20 1922
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70196

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70196

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2958 Cedar Ave ST.; 13 WARD)

2-FULL NAME Agnes E. Kerkhoff.

(a) RESIDENCE. NO. 2958 Cedar Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. WITH CORRECT SPELLING. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: William H. Kerkhoff deceased

6 DATE OF BIRTH (month, day, and year): Nov 5th 1857

7 AGE — Years: 65 — Months: 1 — Days: 13 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jos. Bilby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Caroline Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Miss Kerkhoff 2958 Cedar Ave

15 Filed DEC 19 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk. Hans.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1922, to Dec. 18, 1922, that I last saw her alive on Dec. 17, 1922, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) F. F. Maclin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Stamford

DATE OF BURIAL: Dec 30 19 22

20 UNDERTAKER: A. S. Marshall

ADDRESS: 3539 Falls Road

Spec.—1-10-21—M&T—1500 Bks.

D70197 HEALTH DEPARTMENT—CITY OF BALTIMORE D70197

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1125 William St ST., 24 WARD)

2-FULL NAME Henry A Fray.

(a) RESIDENCE NO. 1125 William St ST., 24 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gertrude Fray.

6 DATE OF BIRTH (month, day, and year): July 6 - 1880

7 AGE: Years 42 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William Fray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Emma Craft

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Gertrude Fray. 1125 William St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 17. 1922

17 I HEREBY CERTIFY, That I attended deceased from December 11, 1922. to December 17. 1922.

that I last saw him alive on December 16. 1922.

and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Uraemia.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Chronic Interstitial Nephritis (duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) E D Buxton, M. D.

12/18. 1922 (Address) 301 Elm St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem DATE OF BURIAL 12-20 1922

20 UNDERTAKER: E & B Hurle ADDRESS 115 E West St

ROBERT B. KRAUTER
REGISTRAR
DEC 22 1922
BUREAU OF VITAL STATISTICS

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70198

CERTIFICATE OF DEATH.

129

D70198

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2nd & Ninth St Hospital ST., Fairfield WARD)

2-FULL NAME Michael H Frey.

(a) RESIDENCE NO. Mag Hanfield ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Frey.

6 DATE OF BIRTH (month, day, and year) April 8 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	8	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Georg Frey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Elmer B Frey. (Address) 122 S. 8th St. City

15 Filed DEC 19 1922, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 - 1922, to Dec 17 1922,
that I last saw him alive on Dec 16 1922
and that death occurred, on the date stated above, at 3 25 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
Nephritis
(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) .....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Examination of Urine
(Signed) Wilhelm 19 Jeff, M. D.
, 19 (Address) 816 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross aaa	12-19 1922
UNDERTAKER	ADDRESS
Orb Hanke.	115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE. PHYSICIANS should give information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Wolf.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70199

CERTIFICATE OF DEATH.

129 D70199

REGISTERED NO.

1-PLACE OF DEATH

2-CITY OF BALTIMORE: (No.) 1715 N Lanvale ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest A. Wolf. Jr.

(a) RESIDENCE NO. 1715 N Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabella C Dilworth

6 DATE OF BIRTH (month, day, and year) Oct 2 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance agt

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Metropolitan Life Ins Co

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Ernest A Wolf.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Augusta Gissler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ernest A. Wolf Jr

(Address) 120 N. Hanover apt

15 Filed DEC 19 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 17 1922

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1922, to Dec. 17, 1922, that I last saw h[illegible] alive on Dec. 17, 1922, and that death occurred, on the date stated above, at 2.40 p m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs & Urinalysis

(Signed) Homer C. Todd M. D.

(Address) 135 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL DEC. 20 1922

20 UNDERTAKER Wm Chas A J Ridder — ADDRESS 600 N Arlington Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED OUT EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70200 D70200

CERTIFICATE OF DEATH.

188-001

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Northern Int [redacted] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leslie P. Tuchton

(Residence in Baltimore: No. 805 Wellington st St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, March (Month) 8 (Day), 1902 (Year)

7-AGE, 20 yrs. 9 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... Tin and sheet iron worker
(b) General nature of industry, business, or establishment in which employed (or employer)... Thos Ginglings

9-BIRTHPLACE, (State or Country), Franklinville Md.

PARENTS.

10-NAME OF FATHER, Wm Tuchton.

11-BIRTHPLACE OF FATHER (State or Country), Franklinville Md

12-MAIDEN NAME OF MOTHER Mary Flowers.

13-BIRTHPLACE OF MOTHER (State or Country), Fork Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Tuchton

(Address) 805 Wellington st

15-

Filed....., 191.....

ROBERT A. KRAUS
Burial Permit Clerk

DEC 19 1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 16 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to *his death on the day stated above.

The CAUSE OF DEATH* was as follows:

I. Injuries from
Railroad Accident
Struck by Engine

(Duration)....yrs. 0 mos....ds.

CONTRIBUTORY (Secondary)

(Duration)....yrs....mos....ds.

(Signed) [redacted] M. D.
(Coroner.)

Dec 19, 1922 (Address) 573 Poland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem. DATE OF BURIAL, Dec 19, 1922

20-UNDERTAKER Walter R. McElfresh ADDRESS 800 Wellington St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS will note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15421 5 25 P.M. D70201 90 D70201

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Side

(a) RESIDENCE NO. 611 Eager St ST., WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) Dec 9 - 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	-	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coffee Grinder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 086

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ulrich Side

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed DEC 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1922, to Dec 17 - 1922, that I last saw him alive on Dec 17 - 1922, and that death occurred, on the date stated above, at 5 25 P. m.

The CAUSE OF DEATH* was as follows:

Senility, Arteriosclerosis.
Myocardiac Insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R Bagg, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery DATE OF BURIAL Dec. 20 1922

20 UNDERTAKER Henry Hosch & Son ADDRESS 120 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should be careful in filling out information should be carefully supplied. AGE, so that it may be properly classified. Exact statement of OCCUPATION is very important CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D70202 — 1500 Bks.

D70202

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 101-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Cathedral ST., 11 WARD)

2-FULL NAME Solomon B. Frazier

(a) RESIDENCE NO. 1012 Cathedral ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nannie Frazier

6 DATE OF BIRTH (month, day, and year) Sept. 6-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 166

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Chase Bros Rockville Md

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant John L. Frazier

(Address) 219 Saratoga Westminster Md

15 Filed ....., 19 ..... ROBERT R. KRAUTER Registrar

DEC 19 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-11, 1922, to 12-18, 1922, that I last saw him alive on 12-18, 1922, and that death occurred, on the date stated above, at 6.48 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) auricular fibrillation

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John L. Dorsey, M. D.

, 19 (Address) 1008 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Dec 20 1922

20 UNDERTAKER H. Lander Sons ADDRESS 1711 Pied

Spec.—1-10-21—M&T—1500 Bks.

D70203

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70203

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No.) ..... ST., (WARD) 15

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Richardson

(a) RESIDENCE NO. 3400 Walbrook Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of she lite Mary E. Richardson

6 DATE OF BIRTH (month, day, and year) July 8 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Eaton Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Mrs Helen L. Richardson

(Address) 3401 Westbrook Ave

15 Filed . 19 ROBERT R. KRAUTER, Registrar

Burial Permit

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item should be stated EXACTLY. PHYSICIANS should be careful in information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 18 1922

17 I HEREBY CERTIFY, That I attended deceased from December 10 1922 to Dec 18 1922, that I last saw h— alive on Dec 18 1922, and that death occurred, on the date stated above, at 12.50 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma / Stomach

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 12/13/22

Was there an autopsy? No

What test confirmed diagnosis? Patient

(Signed) James Hubert Wiseman, M. D.

1922 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemy

DATE OF BURIAL Dec 19 1922

20 UNDERTAKER Jos Jorden & Son

ADDRESS 217 S. Ba

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70204

CERTIFICATE OF DEATH.

90 D70204

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2605 Roslyn Ave St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johanna Reiser

(Residence in Baltimore: No. 508 Columbia Ave St.; 76 yrs., 6 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 28, 1846 (Month) (Day) (Year)

7-AGE, 76 yrs. 6 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Geo. Wm Bartholomai

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Shoen

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Wm Reiser

(Address) 508 Columbia Ave

15- DEC 19 1922 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, DEC. 17th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1922 to DEC 17 1922, that I saw h.. alive on DEC 17th 1922 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Dec 17, 1922 (Address) 1334 E. Lafayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Dec. 20, 1922

20-UNDERTAKER for Sanders & Son — ADDRESS 217 S. Pace

N. B.—Every item of information should be carefully supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70205

CERTIFICATE OF DEATH.

74-001

D70205

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 Dolphin ST., 11 WARD)

2-FULL NAME Georgiana Smith

(a) RESIDENCE No. 218 Dolphin ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. This information should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Raymond Smith (Address) 1420 McCulloh St.

15 Filed DEC 19 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1922 to Dec 17, 1922, that I last saw h. alive on Dec 17, 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Paralysis 7 hours

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage 7 hours

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Observed

(Signed) John H. Fatzpatrick, M. D.

1/8 1923 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. — DATE OF BURIAL Dec 18 1922

20 UNDERTAKER Theodore C. Wirth — ADDRESS 1340 W. Fayette St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70206 D70206

CERTIFICATE OF DEATH. 100-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 418 N. Chester ST., 6 WARD)

2-FULL NAME Lillian E. Harp

(a) RESIDENCE NO. 418 N. Chester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 10-16

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	6	9	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Harry W. Harp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lillian B. Tellis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry W. Harp
(Address) 418 N Chester

15 Filed DEC 19 1922, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/17 1922

17 I HEREBY CERTIFY, That I attended deceased from 11-1, 1922 to 12-17, 1922
that I last saw h alive on 12-12, 1922
and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:
Acute Tonsilitis, Pneumonia (Bronchial) Endocarditis, acute Septicemia General Anasarca
(Duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Finding
(Signed) Fred Burgha, M. D.
19 (Address) 1000 Hall Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	12/19 1922
20 UNDERTAKER Philip Stern's	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Special (1902) Series 1500 Bks. D70207

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70207

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 S. Garrison Ln. ST., 20 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Husing

(a) RESIDENCE NO. 109 S. Garrison Ln. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if of foreign birth? 80 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: late John D. Husing

6 DATE OF BIRTH (month, day, and year): Sept 30/1822

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
100	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Brooklyn N.Y.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.Y.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y.

14 Informant: Lillie MacClements

(Address) 2804 Guilford Av

15 Filed DEC 19 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/17 1922

17 I HEREBY CERTIFY, That I attended deceased from June, 1922 to Dec 17, 1922, that I last saw h[illegible] alive on Dec. 16, 1922, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Senility

Bronchitis

(duration) ... yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Gilchrist Dudley M. D.

, 19 (Address) 2226 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL 12/20 1922

20 UNDERTAKER: Philip J. Henry

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK. [illegible] should be stated EXACTLY. PHYSICIANS should also mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec. 1700 3500 Bks. D70208

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70208

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 842 N. Pat. Pk Ave ST. WARD)

2-FULL NAME August E. Joeckel

(a) RESIDENCE NO. 842 N. Pat. Pk ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if of foreign birth? 43 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida M. Joeckel

6 DATE OF BIRTH (month, day, and year): Sept 7-65

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
57	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer): Bor Mnf'g 842

(c) Name of employer: Himself

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Carl Joeckel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Ida M. Joeckel 842 N. Pat. Pk Ave

15 Filed DEC 6 1922 ROBERT R. KNABE, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/18 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 10 19 22, to Dec 18th 19 22, that I last saw h[illegible] alive on Dec 17th 19 22, and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Cons.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 842 N. Pat. Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: ~~Baltimore~~ London Park — DATE OF BURIAL 12/21 1922

20 UNDERTAKER: Philip Henry — ADDRESS 2016 Auburn

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE MUST BE FILLED OUT IN FULL. PHYSICIANS should be careful in the statement of AGE. AGE should be stated EXACTLY. PHYSICIANS should be careful in the statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70209

CERTIFICATE OF DEATH.

133 D70209

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2727 Belair Road ST., 8 WARD)

2-FULL NAME William Schultze

(a) RESIDENCE NO. 2727 Belair Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE, should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 9 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	70	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 1906

(c) Name of employer Baltimore Dry

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Rudolph B. Schultze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Hoffmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma E. Schultze (Address) 2727 Belair Road

15 Filed DEC 19 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1922, to Dec 17, 1922, that I last saw him alive on Dec 16, 1922, and that death occurred, on the date stated above, at 0235 A m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Senility

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm D Forge M. D.

(Address) Corse & Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Dec 19 1922

20 UNDERTAKER John H. Denny — ADDRESS 715 Light St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70210 D70210

CERTIFICATE OF DEATH.

45

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1009 Dallas ST., 7 WARD)

2-FULL NAME Alfred Myer

(a) RESIDENCE NO. 1009 Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Kilduff

6 DATE OF BIRTH (month, day, and year): Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	61	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Peter's Auto Co.

606

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Alice K. Myer

(Address): 1009 Dallas St.

15 Filed DEC 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 17th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 10th, 1922, to Dec 11th, 1922, that I last saw h[illegible] alive on Dec 6th, 1922, and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) 2yrs 6mos ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) H. C. Parker, M. D.

12/15, 1922 (Address) 1114 Hartman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cemetery — DATE OF BURIAL: 12/19, 22

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

Spec.—1-10-21—M&T—1500 Bks.

D70211

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70211

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 Whatcoat ST., 16 WARD)

2-FULL NAME John Richard Hawkins

(a) RESIDENCE NO. 1106 Whatcoat ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Bessie Hawkins

6 DATE OF BIRTH (month, day, and year) Sept 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Richard Hawkins

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hudson

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant John Mason
(Address) 1106 Whatcoat st

15 Filed DEC 19 1922 19..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1922, to Dec 18, 1922, that I last saw h.. alive on Dec 17, 1922 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Sputum

(Signed) E. William Frey, M. D.

12/19, 1922 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Dec 20 19 22

20 UNDERTAKER Theodore F. Delmar

ADDRESS 1303 Pres Ave

Spec.—1-10-21—M&T—1500 Bks.

D70212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70212

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2826 Penna. Ave. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cathrine Veronica Fallon

(a) RESIDENCE NO. 2826 Penna. Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, ~~widowed, or divorced~~ of (or) WIFE of Thomas Edward Fallon

6 DATE OF BIRTH (month, day, and year) Oct. 36th 1885

7 AGE — Years: 37 — Months: 1 — Days: 19 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Timothy McCarthy

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) District of Columbia

12 MAIDEN NAME OF MOTHER Frances L. McGee

13 BIRTHPLACE OF MOTHER (city or town) Howard County (State or country) Maryland

14 Informant Mrs. Francis L. McCarthy (Address) 2826 Penna Ave Balto. Md

15 DEC 19 1922 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 18th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17th 1922, to Dec. 18th 1922, that I last saw her alive on Dec. 18th 1922, and that death occurred, on the date stated above, at 9:00 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Routine

(Signed) Elbert C. Reitzel M. D.

12/18 1922 (Address) Cor. Pa. & Fulton Aves. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec 21 1922

20 UNDERTAKER: Josiah Oyler — ADDRESS: 1600 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70213

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70213

CERTIFICATE OF DEATH

111-001

1-PLACE OF DEATH Maryland General Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

2-FULL NAME Mr Joseph A. Garrett

(a) RESIDENCE NO. 3840 Reisterstown Road WARD Balto
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 25-1874

7 AGE: ~~forty eight~~ 48 Years 4 Months 24 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pittsburg Pa
(State or country)

PARENTS

10 NAME OF FATHER Henry Garrett

11 BIRTHPLACE OF FATHER (city or town) & England.
(State or country)

12 MAIDEN NAME OF MOTHER Rachel Braithwaite

13 BIRTHPLACE OF MOTHER (city or town) & England.
(State or country)

14 Informant Evelyn L Garrett
(Address) 3840 Reisterstown Road.

15 Robert F. Barrick, Registrar

Filed DEC 19 1922, 19 ..... Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 18th, 1922, to Dec 19th, 1922,

that I last saw h alive on Dec 19th, 1922,

and that death occurred, on the date stated above, at 5.50 a.m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Dec 14/22

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) James Hubert Wilkerson, M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brenwille Pa — DATE OF BURIAL: Dec 20 19 22

20 UNDERTAKER: Jno. Syfer — ADDRESS: 16 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED EXACTLY. PHYSICIANS should be careful in giving information. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. This information is very important.

(McCarrick) ✓

Spec.—1-10-21—M&T—1500 Bks.

D70214

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70214

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. McCarrick

(a) RESIDENCE NO. 1125 2d Pre. Con ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 7-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	60	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 109

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Peter McCarrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Hosp. Records Mercy Hospital

15 Filed DEC 19 1922, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 17 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 9, 1922, to Dec 17, 1922,

that I last saw h[illegible] alive on Dec 17, 1922,

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary): Chronic Pal. Nephritis

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? (No) Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) T. J. Kernan M.D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 12/21 1922

20 UNDERTAKER: Chas. F. Evans & Son — ADDRESS: 11 West Royal Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70215

CERTIFICATE OF DEATH.

74-001

D70215

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat ST.: 28 WARD)

2-FULL NAME Catherine McShane

(a) RESIDENCE. No Mt Hope Retreat ST., 28 WARD.

(Usual place of abode) Died Nov 20 - 1922

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

In Baltimore City

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Mr McShane

6 DATE OF BIRTH (month, day, and year) April 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	57	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Sheean

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) Ireland

12 MAIDEN NAME OF MOTHER Mary Mannyon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?) Ireland

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed ... 19... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 20th, 1922, to Nov 17, 19..., that I last saw h... alive on Nov 17, 19..., and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage - L. Hemiplegia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Depressive Psychoses

(duration) 2 yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/20 1922
20 UNDERTAKER Chas P. Evans & Son	ADDRESS Mt Royal Ave

DEC 19 1922

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. All information should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70216 HEALTH DEPARTMENT—CITY OF BALTIMORE D70216

CERTIFICATE OF DEATH. 161-002

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1019 N. Payson St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marian Hoffman

(a) RESIDENCE. No. 1019 N. Payson St. WARD. Lifetime

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Anderson Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Amita Sollers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Andrew Hoffman

(Address) 1019 N. Payson St

15 Filed Robert E. Partridge, 19 Registrar

Burial Permit Clerk.

EC 19 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 18 1922

17 I HEREBY CERTIFY, That I attended deceased from DEC 12, 1922, to DEC. 18, 1922, that I last saw her alive on DEC 18, 1922, and that death occurred, on the date stated above, at 1250 P. m.

The CAUSE OF DEATH* was as follows: see note on back

Injuries to head - in instrumental delivery DEC. 12-1922

(duration) yrs. mos. 6. ds.

CONTRIBUTORY (Secondary) Insufficient Ossification

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stone

(Signed) George C. Shannon M. D.

, 19 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Dec. 19 1922
20 UNDERTAKER Lilly & Zeile	ADDRESS 403 N. Gay St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. Fill in all items EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D70217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70217

CERTIFICATE OF DEATH.

X 46

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 28 Glenmore avenue St.; 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Ella Frances Hostrand

(Residence in Baltimore: No. 28 Glenmore Avenue St.; ....yrs., 6 mos. ....ds.)

Hamilton

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, March 17, 1854 (Month) (Day) (Year)

7-AGE, 68 yrs. 7 mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Home
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Housewife

9-BIRTHPLACE, (State or Country), Queens Co New York

PARENTS.

10-NAME OF FATHER, Benjamin F. Accuberiew

11-BIRTHPLACE OF FATHER (State or Country), New York City N.Y.

12-MAIDEN NAME OF MOTHER Elizabeth Thomas

13-BIRTHPLACE OF MOTHER (State or Country) Queens Co N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Ellert Hostrand

(Address) 28 E. Glenmore Ave.

15-

Robert F. Harrison,

Filed ..... 191.....

Registrar.

31922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 18, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 16 1922, to December 18 1922, that I saw h.. alive on December 17 1922, and that death occurred, on the date stated above, at 1.50 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

(Duration) One yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. 5 ....ds.

(Signed) Hosanna Whitbeck M. D.

(Address) 1618 Goodrich Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Brooklyn N. Y.

19-PLACE OF BURIAL OR REMOVAL, Cypress Hill Cem Brooklyn N.Y. DATE OF BURIAL, Dec 20, 1922

20-UNDERTAKER Mr. & Mrs. John W. Teufel & Son ADDRESS 807 N. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70218

D70218

CERTIFICATE OF DEATH.

147

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1101 N. Monroe St. 16 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanch Lillian Miranda

(a) RESIDENCE. No. 1101 N. Monroe St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Salvatore Miranda

6 DATE OF BIRTH (month, day, and year) Sept 16 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Gilbert C Kuhns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Anna Leight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs. Anna Kuhns

(Address) 1405 N. Fulton Ave

15 Filed , 19 Registrar

DEC 19 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1922, to Dec 18, 1922, that I last saw her alive on Dec. 18, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Myo-carditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. C. Comer, M. D.

12 19 22 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 19 1922
20 UNDERTAKER	ADDRESS
F. B. Shepherd	2236 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70219

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70219

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3406 Old York Road ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred V. Gleason

(a) RESIDENCE. NO. 3406 Old York Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apl. 23-1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) Health Dept.

(c) Name of employer State Board of Health

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER S. Frank Gleason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER Laura M. Stonebraker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co., Md.

14 Informant Nellie F. Duffett
(Address) 115 N. Gilmor Street

15 Filed Dec 19 1922 Robert F. Carrick Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1922

17 I HEREBY CERTIFY, That I attended deceased from March, 1922, to Dec 19, 1922, that I last saw h[illegible] alive on Dec 18, 1922, and that death occurred, on the date stated above, at 12[illegible] [illegible] m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bacilli in sputum

(Signed) Charles O'Donovan, M. D.

Dec 19, 1922 (Address) 3 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Ignatius Cemetery, Md. Hickory	12/21/1922
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	924 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated, so that it may be properly classified. See instructions on back of certificates. TION is very important.

DEC 19 1922

D70220 HEALTH DEPARTMENT—CITY OF BALTIMORE D70220

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C. 90

City of BALTIMORE: (No. 3605 Garrison Ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Ann Della

(Residence in Baltimore: No. 3605 Garrison Ave. St.; 86 yrs., 1 mos., 11 ds.)

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: November (Month) 6 (Day) 1836 (Year)

7-AGE: 86 yrs. 1 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House-work
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Robert Ross

11-BIRTHPLACE OF FATHER, (State or Country): Somerset Co. Md.

12-MAIDEN NAME OF MOTHER: Matilda Ford

13-BIRTHPLACE OF MOTHER, (State or Country): Somerset Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora E. Jones (Daughter)

(Address) 3605 Garrison Ave

15- Robert P. Harrison,

Filed ..... 192.....

Registrar.

DEC 19 1922

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 17 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) No history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner)

Dec. 19 1922 (Address) 7542 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Mount Olivet — DATE OF BURIAL: Dec 20 1922

20-UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

(Vohden)

D70221 HEALTH DEPARTMENT—CITY OF BALTIMORE D70221

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. ..... St., 9 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Vogden

(Residence in Baltimore: No. 1236 E. North-ave St.; 57 yrs.. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 19 1922

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6-DATE OF BIRTH: ..... 1..... (Month) (Day) (Year)

7-AGE: 57 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fisherman
(b) General nature of industry, business, or establishment in which employed (or employer): 161

9-BIRTHPLACE, (State or Country): Md

PARENTS:

10-NAME OF FATHER: Sam. Vogden

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Annie Wissmann

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ann Waibel Daughter

(Address) 624 N. Lexington

15- Robert F. Hartnett, 1922

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec 17 27 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cirrhosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D. (Coroner)

Dec 19 1922 (Address) 1629 22

*State the Disease Causing Death, or, in deaths from Violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cem. DATE OF BURIAL: Dec 20th 1922

20-UNDERTAKER: Leo G. Cook ADDRESS: North & Harford Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70222

CERTIFICATE OF DEATH.

4 90 D70222

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 681 N. Fayette St.; WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mina Bernhard

(Residence in Baltimore: No. 681 N. Fayette St.; 72 yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 26, 1850 (Month) (Day) (Year)

7-AGE, 72 yrs. 6 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Lazarus Bernhard

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Rachel Stern

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. Bernhard

(Address) 681 N. Fayette St.

15 DEC 20 1922 Filed....., 191.. ROBERT R. KRAUTER, Burial Permit Clerk.....

DEC 20 1922 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 19, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 11 1922, to Dec. 19 1922, that I saw her alive on Dec. 18 1922, and that death occurred, on the date stated above, at 12 50 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Henry H. Wentzel M. D.

Dec. 19, 1922 (Address) 724 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Hebrew Friendship — DATE OF BURIAL, Dec. 21 1922

20-UNDERTAKER J. Ahrens & Co — ADDRESS 611 Mad

D70223

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179

D70223

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. near York St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip Stewart

(Residence in Baltimore: No. 53 N Wood St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widow(er), or Divorced. (Write the word.): Widower

6-DATE OF BIRTH: ..... (Month) ..... (Day) ..... (Year)

7-AGE: 72 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country): Penn

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Penn

12-MAIDEN NAME OF MOTHER:

13-BIRTHPLACE OF MOTHER, (State or Country):

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. J. Riley

(Address) 1639 Broadway

Filed DEC 20 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec. 19 (Month) (Day) 192.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, and find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Part I. (a) Hypostatic congestion
(b) Fracture of skull and shock
(c)
(d)
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)
Dec 19 192.. (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Ct — DATE OF BURIAL: Dec. 20th 1922

20-UNDERTAKER: N. E. Blum & Son — ADDRESS: 108 W. Monument

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70224

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002 D70224

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 Patapsco ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis August Ehart

(a) RESIDENCE. No. 1220 Patapsco ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 29-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Ballo (State or country)

PARENTS

10 NAME OF FATHER August Ehart

11 BIRTHPLACE OF FATHER (city or town) Ballo (State or country)

12 MAIDEN NAME OF MOTHER Catherin Kemper

13 BIRTHPLACE OF MOTHER (city or town) Ballo (State or country)

14 Informant Mrs Catherin Kemper (Address) 1220 Patapsco St

15 Filed DEC 20 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 29 1922, to Dec 19 1922, that I last saw him alive on Dec 16 1922, and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Congenital Heart.

(duration) — yrs. — mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. C. Conser, M. D.

12 19 1922 (Address) 1101 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem — DATE OF BURIAL: 12-20 1922

20 UNDERTAKER: E B Hale — ADDRESS: 115 E West St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70225

D70225

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH City of BALTIMORE: (No. 105 Broad Alley St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Chinn

(Residence in Baltimore: No. 105 Broad Alley St.; yrs..... mos..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Va

PARENTS.

10-NAME OF FATHER: James Chinn

11-BIRTHPLACE OF FATHER, (State or Country): Va

12-MAIDEN NAME OF MOTHER: Rebecca Lewis

13-BIRTHPLACE OF MOTHER, (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Winder

(Address) 105 Broad alley

15-

Filed DEC 20 1922

ROBERT R. KRAUTER Registrar.

Deputy Registrar or Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 19 (Month) (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Unknown mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Hutton M. D. (Coroner.)

Dec 6 192.2 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

Balto. Md.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	....., 19...
20-UNDERTAKER,	ADDRESS
Commissioner Health	DEC 1 1922

40

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70226

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70226

CERTIFICATE OF DEATH.

161-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 So Central Ave ST.: 13 WARD)

2-FULL NAME Boy Constantine

(a) RESIDENCE. NO. 119 So Central Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state EXACTLY. AGE should be stated carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Constantine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Julia Occimino

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: J. Constantine
(Address) 119 S Central Ave

15 Filed . 19 ROBERT R. KRAUTER Registrar

DEC 20 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1922 to Dec 19, 1922

that I last saw her alive on Dec 19, 1922

and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Aborting Foetus -
Causing - Fourth Labor -
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Size of Foetus
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph D. Valentine M D, M. D.

Dec 19, 1922 (Address) 14 So Ann St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent's — DATE OF BURIAL: Dec 20 1922

20 UNDERTAKER: Wendell Appel — ADDRESS: 370 Lex

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70227

CERTIFICATE OF DEATH.

112 ✓ D70227

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 191 N. Calhoun St ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Birdie VanKeuren Tyler

(a) RESIDENCE. No. 19 N. Calhoun St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry A Tyler

6 DATE OF BIRTH (month, day, and year) Sept 8 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk
(State or country) Va

PARENTS

10 NAME OF FATHER Jacob VanKeuren

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Susan A Peter

13 BIRTHPLACE OF MOTHER (city or town) Norfolk
(State or country) Va

14 Informant Frank M Russ
(Address) 2137 Hammond Ave

15 Filed DEC 20 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1922, to Dec 18, 1922, that I last saw h[illegible] alive on Dec 18, 1922, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Catt. J. Murray M. D.

12-19-1922 (Address) 510 N. Mount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 20 1922
20 UNDERTAKER	ADDRESS
L. Sander Sons	1701 Park Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70228 — 101-001 D70228

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1035 St Paul ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Lavinia Stewart

(a) RESIDENCE. No. 1035 St Paul ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced (write the word): Widow

5a ~~If married~~, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE OF: Dr James H. Stewart

6 DATE OF BIRTH (month, day, and year): 1851-2-11

7 AGE — Years: 71 — Months: 10 — Days: 8. — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co Md.

PARENTS

10 NAME OF FATHER: Samuel E Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis Md.

12 MAIDEN NAME OF MOTHER: Adelaide Slemaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundel Co Md.

14 Informant (Address): Mrs. James H Stewart 1035 St Paul St.

15 Filed DEC 20 1922 19 ROBERT R. KRAUTER. Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 19- 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 15- 1922, to Dec 19- 1922, that I last saw her alive on Dec 18- 1922, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) ....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? None —

(Signed) Oliver W. Lemmon, M. D.

Dec 19 1922 (Address) 1327 Park Ave —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — DATE OF BURIAL: 12-21 1922

20 UNDERTAKER: Newman Funeral Home Co. — ADDRESS: McCulloh Orchard

Spec.—I-10-21—M&T—1500 Bks.

1922
34
1588

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70229

CERTIFICATE OF DEATH.

D70229

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1105 N Gilmor ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jackson

(a) RESIDENCE NO. 1105 N. Gilmore ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Jackson

6 DATE OF BIRTH (month, day, and year) June 1888

7 AGE: Years 34 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 010

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Andrew Goode

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Oakley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant: John Goode (Address) 1105 N. Gilmor St.

15 Dec 20 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-19 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec-12 1922 to Dec-18 1922

that I last saw her alive on Dec-15 1922

and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Calvert M. D.

Dec 20 1922 (Address) 2039 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn | DATE OF BURIAL: Dec 22 1922

20 UNDERTAKER: Clarence E. Wright | ADDRESS: 364 N Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70230 D70230

CERTIFICATE OF DEATH.

10 V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 W Saratoga St. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Rosenstock

(a) RESIDENCE No. 1819 W Saratoga St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed or Divorced (write word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19-1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Nelson Rosenstock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Reba Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Reba Coplin (Address) 1819 W. Saratoga

15 Filed DEC 20 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-19 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov-25 1922 to Dec-19- 1922, that I last saw h- alive on Dec-19- 1922, and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Dysentery by Heart,

(Tonsillar) Diphtheria (duration) yrs mos 20 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 26 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Culture

(Signed) Marion W Shook M. D.

Dec-19- 1922 (Address) 806 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 12/20 1922

20 UNDERTAKER Wm Cook — ADDRESS 502 E Nath

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70231

CERTIFICATE OF DEATH.

188-002

D70231

Registered No. C.....

1-PLACE OF DEATH: Curtis Ave. near Cypress St.

City of BALTIMORE: (No. ..... Curtis Bay. ..... St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Frank Schickton.

30 ----------

(Residence in Baltimore: No. 21 Locust St. Curtis Bay. St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH: March 7th. 1857. (Month) (Day) (Year)

7-AGE: 62 yrs. 9 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Bohemia, Austria

PARENTS.

10-NAME OF FATHER, Frank Schickton.

11-BIRTHPLACE OF FATHER, (State or Country) Bohemia, Austria.

12-MAIDEN NAME OF MOTHER, Mary. ----------

13-BIRTHPLACE OF MOTHER, (State or Country) Bohemia, Austria.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Tena Schickton. (wife)

(Address) 21 Locust St. Curtis Bay.

15-

FILED DEC 20 1922

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 17th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidentally run over by a street car.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Dec 19 '22 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cedar Hill DATE OF BURIAL. Dec. 19 1922

20-UNDERTAKER. George L. Schwab ADDRESS. 1 Pulaski St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70232

D70232

CERTIFICATE OF DEATH. John H Baader

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 10 WARD) 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Baader.

(a) RESIDENCE NO. 1236 E. Eager St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Fannie A. Baader

6 DATE OF BIRTH (month, day, and year) July 1st 1866

7 AGE: Years 56. Months 5 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Motorman

(b) General nature of industry, business, or establishment in which employed (or employer): United Railways Co

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER M. Baader

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs. Fannie A. Baader (Address) 1236 E Eager St

15 Filed DEC 20 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1922, to Dec 19, 1922, that I last saw him alive on Dec 19, 1922, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) J. Aschenasch, M. D.

(Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery DATE OF BURIAL: Dec. 22 1922

20 UNDERTAKER: Henry Hoerth Sons ADDRESS: 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D70233

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2045 E 32nd ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma F Korfman

(a) RESIDENCE NO. 2045 E 32nd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Albert A Korfman

6 DATE OF BIRTH (month, day, and year): June 27th 1856

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Wempe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sarah Hammel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Albert A Korfman

(Address) 2045 E 32nd st

15 Date DEC 20 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922, to Dec 18, 1922, that I last saw her alive on Dec 18, 1922 and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.
Aortic Insufficiency.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert G Webster M.D. M. D.

, 19 (Address) 703 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Dec 21st 1922

20 UNDERTAKER: George Schilling & Sons

ADDRESS: 1126 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70234

CERTIFICATE OF DEATH.

100-001 D70234

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 811 S. Ann ST., 2 WARD)

2-FULL NAME Anna Protasiewicz (Protasiwicz)

(a) RESIDENCE NO. 811 S. Ann ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 10-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Anton Protasiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josepha Rudnicka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anton Protasiewicz (Address) 811 S. Ann

15 DEC 20 1922 ROBERT R. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 14 1922

17 I HEREBY CERTIFY, That I attended deceased from December 12, 1922, to December 14, 1922, that I last saw h alive on December 14, 1922, and that death occurred, on the date stated above, at 3.00 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inspiration

(Signed) J. Neudorfer, M. D.

12-15 19 (Address) 722 N. Ann St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

UNDERTAKER Wm. Fiackowski

DATE OF BURIAL 12/20 1922

ADDRESS 1618 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D70235

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70235

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 631 W. Mosher ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank C. Watson

(a) RESIDENCE NO. 631 West Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Watson

6 DATE OF BIRTH (month, day, and year) Sept 23 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	72	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 650

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Charles Watson

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Henriette Zimmerman

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto.

14 Informant Mrs Annie E. Watson

(Address) 631 West Mosher St

15 Filed DEC 28 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1922

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1922, to Dec 19, 1922,

that I last saw h... alive on Dec 18, 1922,

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Left sided Hemiplegia apoplexy.

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) High blood pressure

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? —

(Signed) Chas. C. Conser, M. D.

12/19 1922 (Address) 1101 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkesburg Pa — DATE OF BURIAL 12/22 1922

20 UNDERTAKER Eddie M Walker — ADDRESS 723 W Lafayette

D70236

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

47

D70236

REGISTERED No. C

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Homewood Apartment ST.: 17 WARD)

2 FULL NAME Mabel Eastman Dorsey

(Residence in Baltimore: No. Homewood Apartment Chalk St.: 40 yrs. 1 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~SINGLE~~, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Nov. (Month) 4 (Day), 1882 (Year)

7 AGE: 40 yrs. 1 mos. 13 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Lewis M Eastman Sr.

11 BIRTHPLACE OF FATHER (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary A. Formby

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis M Eastman Jr.

(Address) 1505 Edmondson Ave

15 DEC 20 1922 ROBERT R. KRAUTER, Burial Permit Clerk

Filed ....., 191 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 17 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1922 to Dec 17 1922, that I saw h-er alive on Dec 17, 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cancer of breast with general infection

(Duration) 1 yrs. — mos. — ds

Contributory (SECONDARY)

(Duration) 1 yrs. — mos. — ds.

(Signed) Lewis M Eastman Jr. M. D.

....., 191 (Address) 1505 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: 12/20, 191 22

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D70237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

D70237

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 N Washington ST., 8 WARD)

2-FULL NAME Thos E Bruff

(a) RESIDENCE NO. 1228 N. Washington ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Elizabeth A Bruff

6 DATE OF BIRTH (month, day, and year) Nov 27 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69		21	

8 OCCUPATION OF DECEASED Secretary of

(a) Trade, profession or particular kind of work Md Funeral Benefit Assn

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James A Bruff

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Michaels Md

12 MAIDEN NAME OF MOTHER Elizabeth Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Elizabeth A Bruff 1228 N Washington St

15 Filed DEC 20 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1922, to Dec 18, 1922, that I last saw h~~im~~ alive on Dec 18, 1922 and that death occurred, on the date stated above, at 5.00 P m.

The CAUSE OF DEATH* was as follows:

Ascites - Carcinoma of Sigmoid

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Sigmoid (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) D O Carman, M. D.

12-18 1922 (Address) 1701 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Dec 21 1922

20 UNDERTAKER Henry Lutz

ADDRESS 1203

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70238

CERTIFICATE OF DEATH.

D70238

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE: (No. 1115 Jordan St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Wrigglesworth

(Residence in Baltimore: No. 115 Jordan St. St.; 5 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE MUST BE FILLED OUT BEFORE BURIAL PERMIT IS ISSUED.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Mar. 11 (Month), (Day), 1905 (Year)

7-AGE. 17 yrs. 9 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. at home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Walter Wrigglesworth

11-BIRTHPLACE OF FATHER (State or Country). md

12-MAIDEN NAME OF MOTHER annie Langford

13-BIRTHPLACE OF MOTHER (State or Country). md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) annie Wrigglesworth

(Address) 1115 Jordan st

15-

Filed DEC 20 1922, 191... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec. 19 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1922, to Dec 19 1922, that I saw her alive on Dec 19 1922, and that death occurred, on the date stated above, at 3 45 p m.

The CAUSE OF DEATH* was as follows:

Tuberculosis - Pulmonary

(Duration) one yr. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Dolan M. D.

Dec. 19, 1922 (Address) 1426 E. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL. Dec 22, 191...

20-UNDERTAKER Geo. A. Gibson

ADDRESS 513 Lanvale

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70239

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70239

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 S Potomac ST.: [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angela Sibistowicz

(a) RESIDENCE. NO. 524 S Potomac ST., [illegible] WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. —— ds. How long in U. S., if of foreign birth? 20 yrs. — mos. —— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Pikoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Pikoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Andrew Sibistowicz 524 S Potomac St

15 Filed DEC 20 1922 16 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1922, to Dec 18, 1922, that I last saw h[illegible] alive on Dec 18, 1922, and that death occurred, on the date stated above, at 9-30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Dec 21 1922
20 UNDERTAKER	ADDRESS
Stephen J Kulkowski	1008 S Kinsley

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70240 D70240

CERTIFICATE OF DEATH.

V 160

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 733 E. 23rd St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Krauss

(Residence in Baltimore: No. 733 E. 23rd St.; ....yrs.,....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec. (Month) 1 (Day), 1922 (Year)

7-AGE, ...yrs. 11 mos. 12 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City Md

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Alma H. Krauss

13-BIRTHPLACE OF MOTHER (State or Country), Phila Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel R. Krauss

(Address) 733 E. 23rd St. Baltimore

15- Filed DEC 20 1922, 191... ROBERT R. KRAUTER. Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 19th (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 7th 1922 to Dec 19 1922 that I saw him alive on Dec 17 1922, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Otto M. Wright M. D.

Dec 20 1922 (Address) 18 St. Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Cross

DATE OF BURIAL, Dec 20, 1922

20-UNDERTAKER E. A. Windsor

ADDRESS 501 E 22 St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70241

D70241

CERTIFICATE OF DEATH. — 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2940 W. North Ave. St., 15 Ward)

2-FULL NAME Charles Crook Shaffer

(a) RESIDENCE No. 2940 W. North ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Francis V. Shaffer

6 DATE OF BIRTH (month, day, and year): Nov. 21 1850

7 AGE — Years: 72 — Months: 0 — Days: 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo. E. Shaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Sarah A. White

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Annapolis Md

14 Informant: Grace E. Shaffer (Address) 2940 W. North Ave

15 DEC 20 1922 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 19" 1922

17 I HEREBY CERTIFY, That I attended deceased from April 6 1920, to Dec 19" 1922, that I last saw him alive on Dec 18" 1922, and that death occurred, on the date stated above, at 12.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Health Department T.B. Dr.

(Signed) Herbert E. Zepp, M. D.

Dec 20 1922, (Address) 3048 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cem. — DATE OF BURIAL: Dec 21 1922

20 UNDERTAKER: Chas. Ouitchell — ADDRESS: 1202 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70242

CERTIFICATE OF DEATH.

188-002

D70242

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hebrew Hospital ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fitz Sandler

(Residence in Baltimore: No. 115 Aisquith St. (Hebrew Home) St.; yrs. 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown Dec 19, 1922
(Month) (Day) (Year)

7-AGE, 83 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hebrew Foundling Home

(Address) 115 Aisquith St

15- Filed DEC 20 1922 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 19, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull Central Hemorrhage

Struck by street car.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Watts M. D.
(Coroner.)

Dec 19, 1922 (Address) 118 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mount Hebrew Cem. DATE OF BURIAL, Dec 20, 1922

20-UNDERTAKER Jacob Lewis ADDRESS 1552 Bank

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70243

D70243

CERTIFICATE OF DEATH. 65-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 16 WARD)

2-FULL NAME. Mary Wheeler

(a) RESIDENCE NO. 708 Appleton ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 29 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	19	1	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

009

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John B Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Jennie Rachel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John B Wheeler
(Address) 708 Appleton St.

15 FILED DEC 20 1922
ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 19 22, to Dec 18, 19 22
that I last saw her alive on Dec 18, 19 22
and that death occurred, on the date stated above, at 1.00 P.M.

The CAUSE OF DEATH* was as follows:
Acute Septicaemia
Cerebellum
(duration) yrs mos 29 ds.

CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings Blood Culture Spinal Fluid

(Signed) [illegible], M. D.

, 19 (Address) 1 West Mt. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Dec 21 1922

20 UNDERTAKER: Robt J Turner Inc — ADDRESS 1442 W Broadway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70244

D70244

CERTIFICATE OF DEATH.

44

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1529 Aisquith ST., 9 WARD)

2-FULL NAME Catherine Adams.

(a) RESIDENCE NO. 1529. Aisquith ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word)
F.	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Henry J. Adams

6 DATE OF BIRTH (month, day, and year) March. 24/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

137

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Patrick Finnerty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine. Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant (Address) Margaret Finnerty 1529. Aisquith St.

15 Filed DEC 20 1922 ROBERT R. KRAETER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1922, to Dec 17, 1922, that I last saw h[illegible] alive on Dec 17, 1922 and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Face Bladder

(duration) Unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) Henry Ohlmacher, M. D.

, 19 (Address) 1100 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery. DATE OF BURIAL Dec 21 1922

20 UNDERTAKER Geo. J. Ruth. ADDRESS 1735. Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70245 10 D70245

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1821 N. Gwynn ST., 9 WARD)

2-FULL NAME Edith Taylor

(a) RESIDENCE NO. 1824 N. Gwynn ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 10/25/20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Arthur Taylor

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Edith Taylor

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Edith Taylor
(Address) 1821 N. Gwynn St.

15 Filed DEC 20 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/20 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov ....., 19 22 to Dec 20, 19 22

that I last saw h W alive on Dec 19, 19 22

and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Diphtheria
Pharyngeal

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? uncertain

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Lab Findings + Physical

(Signed) R. J. Gwynn, M. D.

, 19 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	12/20 19 22

20 UNDERTAKER Geo. J. Pentz ADDRESS 1735 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10 M&T—1500 Bks.

D70246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D70246

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

2-FULL NAME William W. Langley

(a) RESIDENCE NO. 654 Lemmon alley ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Eva Langley

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John Langley

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Alice Kennich

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Bayview Hospital
(Address) Balto. Md

15 Filed DEC 20 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1922 to Dec 18, 1922 that I last saw h alive on Dec 18, 1922 and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General Paralysis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Dr. H. Golamitte M. D.

19 (Address) per Dr. I. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Antrim Cemetery	12/20 1922
UNDERTAKER	ADDRESS
Chas Geo Hooper	406 W Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70247 D70247

CERTIFICATE OF DEATH.

112

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 N. Broadway ST.: 8 WARD)

2-FULL NAME Laura Jane Shoemack

(a) RESIDENCE. NO. 1235 N. Broadway ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND OF (or) WIFE of George Shoemack

6 DATE OF BIRTH (month, day, and year) Mch. 29. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William Steer

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary J. Adams

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Annie D. Shoemack (Address) 1235 N. Broadway

15 Filed DEC 20 1922 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18. 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1922, to Dec 18, 1922, that I last saw h. alive on Dec 18, 1922, and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows: Acute Gastro Enteritis

1 Hour (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (?) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Geo F Taylor, M. D.

12/19 1922 (Address) 1267 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	12-21-22 19
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

D70248

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70248

CERTIFICATE OF DEATH. 100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., 28 WARD)

2-FULL NAME Mrs Martha P Heim

(a) RESIDENCE No. 4216 Groveland Ave ST., ... WARD .....
(Usual place of abode) W Arlington (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed or divorced (HUSBAND of) (or) WIFE of Charles P Heim

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48 Yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Eschbach

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Clarentine Shertzer

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Charles P Heim

(Address) 4216 Groveland Ave

15 Filed ..... 19 .....

Robert F. Leyhue

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-19 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-7, 1922, to 12-19, 1922, that I last saw h[illegible] alive on 12-19, 1922, and that death occurred, on the date stated above, at 3 am m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

two weeks (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ..... yrs. one week mos.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Note

(Signed) W C Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chas E Evans Son

DATE OF BURIAL 12/22 1922

20 UNDERTAKER Mt Royal Ave (Loc Cathedral Cem.)

ADDRESS

MARGIN RESERVED FOR CORRECTIONS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 20 1922

Spec. 6-9-19—H. P. Co.—1000 Blks.

D70249

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70249

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH University Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. Lombard & Greene. ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Hann.

(a) RESIDENCE. NO. 43 Maryland Av Westport. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 10, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Hann.

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Myrtle Hann

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Myrtle Hann
(Address) 936 N. Calvert St

15 Filed DEC 20 1922 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/14 1922

17 I HEREBY CERTIFY, That I attended deceased from 9/16/, 1922, to 12/14, 1922,

that I last saw h alive on 12/14, 1922

and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) Thos. Jardon, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Dec 21 1922

20 UNDERTAKER Jno. Syfer

ADDRESS 16 S Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

6240 Bond

Spec.—1-10-21 M&T 1500 Blks.

D70250

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D70250

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 16 WARD)

2-FULL NAME John Kaczwarch

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed Dec 20 1922 Robert F. Barrieau, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19 1922

17 I HEREBY CERTIFY, That I attended deceased from December 9, 1922, to December 19, 1922, that I last saw him alive on December 19, 1922, and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Post

(Signed) Clifford Reese, M. D.

12/20/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus — DATE OF BURIAL Dec 21 1922

20 UNDERTAKER John B Weber — ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D70251

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70251

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 S Patterson Park Ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bielich

(a) RESIDENCE NO. 617 S Patterson Park ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24 1920

7 AGE: Years 2 Months 5 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Wladyslaus Bielik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Sobol

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Mrs Mary Bielik 617 S Patterson Parkway

15 Filed . 19 Robert P Harrison, Registrar

DEC 20 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/19 192

17 I HEREBY CERTIFY, That I attended deceased from 12/17 , 19 22 , to 12/19 , 19 22 ,

that I last saw h alive on 12/17 , 19 22 ,

and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Lung Infection

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jos. H. Bielski, M. D.

Dec 21, 19 22 (Address) 617 S Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Dec 21 1922

20 UNDERTAKER: John McWeber — ADDRESS: 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D70252

CERTIFICATE OF DEATH

Hildebrand 8 48

D70252

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1639 N Bond St. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Margaret L Hildebrand

(Residence in Baltimore: No. 1639 N Bond St.; 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female

4-COLOR OR RACE: White

5-~~SINGLE, MARRIED~~ WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: 12 (Month) 7 (Day), 1862 (Year)

7-AGE: 60 yrs. mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 039

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Martin Madden

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Julia Boyle

13-BIRTHPLACE OF MOTHER (State or country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. Hildebrand

(Address) 1639 N Bond St

15-

Filed ..... DEC 20 1922, 191 Robert P. Harrison, REGISTRAR

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec 18 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 18th, 1922, to Dec 18th 1922, that I saw h[illegible] alive on Dec 18th, 1922, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Left side of the face,

(Duration) ..... yrs. 6 mos. ds

Contributory (SECONDARY) —

(Duration) — yrs. — mos. — ds.

(Signed) William A Bennington M. D.

Dec 19th, 1922 (Address) 1826 Madison St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			

Where was disease contracted, if not at place of death? Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer

DATE OF BURIAL: 12-21, 1922

20-UNDERTAKER: H C Brannigan

ADDRESS 517 N Silver St

Spec.—1-10-21—M&T—1500 Bks.

D70253 HEALTH DEPARTMENT—CITY OF BALTIMORE 74 D70253

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (ST.) 9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lazbrias B. Wilson

(a) RESIDENCE NO. 1918 E. 31st St. (ST.) (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. Wilson.

6 DATE OF BIRTH (month, day, and year): Mar 27 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Captain

(b) General nature of industry, business, or establishment in which employed (or employer): Steam Boat

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Annie E. Wilson

(Address) 1918 E 31st St

15 Filed ..., 19... Robert P. Harrison, Buried Forest Park. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 19 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 11, 1922, to Dec 19, 1922,

that I last saw h[illegible] alive on Dec 19, 1922,

and that death occurred, on the date stated above, at 11 55 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym & Signs

(Signed) D. J. Sullivan, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dimmiset Co Md Deal's Island — DATE OF BURIAL: 12/21/1922

20 UNDERTAKER: Philip Herring — ADDRESS: Crisfield

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED

DEC 20 1922

Spec.—1-10-21—M&T—1500 Bks.

D70254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70254

CERTIFICATE OF DEATH.

31

MARGIN RESERVED FOR BINDING. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 N. Ellwood Av 6 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul E. Nippard

(a) RESIDENCE NO. 29 N. Ellwood Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14 - 02

7 AGE — Years: 20 | Months: 7 | Days: 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Reporter at

(b) General nature of industry, business, or establishment in which employed (or employer) Sun office

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)

PARENTS

10 NAME OF FATHER Paul F. Nippard

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Daisy L. Lewis

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Daisy L. Nippard (Address) 29 N. Ellwood Av

15 Filed , 19 Registrar

DEC 20 1922

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/18 1922

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1920, to Dec. 18, 1922, that I last saw him alive on Dec. 18, 1922, and that death occurred, on the date stated above, at 12-30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Fisher, M. D.

12/19 1922 (Address) 1823 N. Wash St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. | DATE OF BURIAL 12/21 1922

20 UNDERTAKER Philip Stemig | ADDRESS 2016 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70255

CERTIFICATE OF DEATH.

129

D70255

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 332 E 21st St (ST.) 12 (WARD)

2-FULL NAME Charles Tate Morris

(a) RESIDENCE. NO. 332 E 21st St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If ~~married, widowed, or divorced~~ HUSBAND of (or ~~WIFE~~ of): Agnes Buck Morris

6 DATE OF BIRTH (month, day, and year): Jan 21 1845

7 AGE: Years 77 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Ship joiner

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chas. T. Morris Balto. Md.

PARENTS

10 NAME OF FATHER: Chas. T. Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Amelia Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr Morris (Address) 332 E 21st St

15 Filed ... Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1922, to Dec 20, 1922, that I last saw him alive on Dec 19, 1922, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Ch. Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) [illegible] M. D.

12/22/1922 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: 12/25/22

20 UNDERTAKER: H E Nagel and A Broadway

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 20 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70256

CERTIFICATE OF DEATH.

700-001 D70256

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 700 W. Fayette ST.: 4 WARD)

2-FULL NAME Jessie Frances Horton

(a) RESIDENCE. NO. 700 W. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 23 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-28-22.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md. Baltimore

PARENTS

10 NAME OF FATHER James Creedy Horton

11 BIRTHPLACE OF FATHER (city or town) Mobile (State or country) Ala.

12 MAIDEN NAME OF MOTHER Evelyn Wayman

13 BIRTHPLACE OF MOTHER (city or town) Pottsville (State or country) Pa.

14 Informant Evelyn Horton
(Address) 700 W. Fayette St

15 Filed DEC 21 1922, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 14 1922, to Dec. 21 1922, that I last saw her alive on Dec 20 1922, and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? — Physical signs

(Signed) Chester Rile M. D.

12-21 1922 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvert Cemetery

DATE OF BURIAL Dec 21 1922

20 UNDERTAKER Geo J Smith

ADDRESS 1532 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr. Sadler

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Bulletin High

159-02 D70257

D70257

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3215 Esther Place ST., 26 WARD)

2-FULL NAME William G. Nelson

(a) RESIDENCE NO. 3215 Esther Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bernard Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Bessie Bancker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Bernard Nelson
(Address) 3215 Esther Place

15 Filed DEC 21 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1922, to Dec 20, 1922, that I last saw him alive on Dec 19, 1922 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Pulmonalis Congenitum

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Failure of Foramen ovale

Atelectasis Pulmonum (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. G. Sadler, M. D.

Dec 20 1922 (Address) 1 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL Dec 21 1922

20 UNDERTAKER H. Sander & Sons — ADDRESS 1710 Fleet St

Spec.—6-9-19—H. P. Co.—1000 Bks.

Kenna J. Coulk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70258 D70258

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 7 E Pleasant (St.) (Ward) 4

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Kenna Coulk.

(a) RESIDENCE. No. 5 1 E Pleasant ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? All her life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Oliver Coulk

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 68				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md.

PARENTS

10 NAME OF FATHER John Gossaway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emily Whittington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs E V Hyre

(Address) 1823 E Carlton St

15 Filed DEC 21 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1922, to Dec 20, 1922, that I last saw her alive on Dec 14, 1922, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency and Pyelonephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R L Kemper M. D.

, 19 (Address) Highworth & Ed

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Dec 22 1922

20 UNDERTAKER: Henry Perkins & Sons

ADDRESS: 12/22/22

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

Oakenwood.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70259

CERTIFICATE OF DEATH.

74-001 D70259

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. 14 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia ackenwood

(a) RESIDENCE NO. 1419 Brunt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	53	?		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 870

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, md

PARENTS

10 NAME OF FATHER Wm Ackenwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Wm Williams. (Address) 1419 Brunt St

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

DEC 24 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-20 1922

17 I HEREBY CERTIFY, That I attended deceased from 11-25-, 1922, to 12-20, 1922.

that I last saw h e alive on 12-19-, 1922.

and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Senile gangrene of left foot and leg.

(duration) 2 yrs. ? mos ds.

CONTRIBUTORY (Secondary) Hemiplegia - left side (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Richardson Boyle M. D.

12/20 1922 (Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 12/21 1922

20 UNDERTAKER Samuel Hemsley

ADDRESS 578 N Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state information in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70260 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D70260

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 Mosher ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Payne

(a) RESIDENCE NO. 1309 Mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A Payne

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE: Years 62 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co Md

PARENTS

10 NAME OF FATHER Thos Delaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Green

(Address) 1309 Mosher

15 Filed DEC 1 1922. 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18, 1922.

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922 to December 17, 1922, that I last saw her alive on Dec. 17, 1922, and that death occurred, on the date stated above, at 6-25 a m.

The CAUSE OF DEATH* was as follows:

Cronic Interstitial Nephritis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H L White M. D.

(Address) 1118 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: 12/21/22 19

20 UNDERTAKER: Samuel T Hemsley

ADDRESS 578 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 M. H. T. 6 400 Bks.

D70261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70261

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 Penn St ST.; 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Hall —

(a) RESIDENCE. No. 15 Penn ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: Colr.

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: not Known

6 DATE OF BIRTH (month, day, and year): Aug 2 1846

7 AGE: Years 76 ~~1846~~ Months ~~Aug~~ Days ~~2~~ If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter 1846

(b) General nature of industry, business, or establishment in which employed (or employer): not Known

(c) Name of employer: not Known

9 BIRTHPLACE (city or town) (State or country): Howard Co Maryland

PARENTS

10 NAME OF FATHER: Allen Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not Known

14 Informant: John H. Hall - Brother (Address): 541 Mosher St

15 Filed DEC 21 1922, 19.. ROBERT R. KRAUTER Registrar

Bucks Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17— 1922, to Dec 19— 1922

that I last saw him alive on Dec 18— 1922

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

not Known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Samuel A Bain, M. D.

Dec 21 1922 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: not Zion Cem

DATE OF BURIAL: Dec. 24 1922

20 UNDERTAKER: Samuel T. Hemsley

ADDRESS 578 N Bridge St

Spec.—1-10-21—M&T—1500 Blks.

D70262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70262

CERTIFICATE OF DEATH.

100202

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 Hanemann ave ST., 8 WARD)

2-FULL NAME Roselind Scott

(a) RESIDENCE NO. 1912 Hanemann ST., 7 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Since birth ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — — — —

6 DATE OF BIRTH (month, day, and year) 9 January 1922

7 AGE: Years — Months 11 — Days — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant John Scott (Father)
(Address)

15 Filed ....., 19 ..... Registrar

DEC 21 1922 BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1922

17 I HEREBY CERTIFY, That I attended deceased from December 10th, 1922, to December 19, 1922, that I last saw her alive on Dec 18th, 1922, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Contributory)

(duration) — yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Capilary Bronchitis

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? at her home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Thomas Emmis, M. D.

19 (Address) 1026 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL dec 20 1922

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70263

CERTIFICATE OF DEATH.

100-001

D70263

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 ais quith Street ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Slamowitz

(a) RESIDENCE NO. 110 ais quith street ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	White	~~white~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Freida Slamowitz

6 DATE OF BIRTH (month, day, and year) Russia

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Balto St

15 Filed DEC 21 1922 ROBERT R. KRAMER, Registrar

Death Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/20 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1920, to December 20, 1922, that I last saw h[illegible] alive on December 20, 1922, and that death occurred, on the date stated above, at 2158 m.

The CAUSE OF DEATH* was as follows:

Broncho- Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Senility and asthma

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart & Thyroid

(Signed) Milton P Hale, M. D.

, 19 (Address) Wyliesville - Reisterstown Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrens Rosedale — DATE OF BURIAL 12/23 1922

20 UNDERTAKER Jack Lewis 1439 E Balto St — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D70264 D70264

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Hebrew Hosp ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barney Harris

(Residence in Baltimore: No. 110 N. Patterson Pkwy St.; 20 yrs., mos. ds.)

WRITE PLAINLY, WITH INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown (Month) ..... (Day) 1879 (Year)

7-AGE, 43 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abraham Harris

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Minnie Snyder

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Balto St

15- Filed DEC 21 1922 191... ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 20 (Day), 1922 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1922, to Dec. 20 1922, that I saw h[im] alive on Dec 20 1922, and that death occurred, on the date stated above, at 12:30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Paralytic Ileus

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Leonard H. Greenbaum M. D.

....., 191... (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 8 ds. In the State 20 yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 110 N Patterson Pkwy

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosedale

DATE OF BURIAL, 12/22, 1922.

20-UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D70265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70265

CERTIFICATE OF DEATH.

REGISTERED NO. C 6

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Walker ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Brown

(Residence in Baltimore: No. 1617 Walker St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept (Month) 11 (Day), 1895 (Year)

7-AGE, 27 yrs. 3 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Chas. Conway

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margrite Cephus

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ada Ward (sister)

(Address) 1517 N. Mulberry St.

15- Filed DEC 21 1922, 191.... ROBERT R. KRAUTER, Registrar. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 20 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 10 1922, to Dec 20 1922, that I saw her alive on Dec 18 1922, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulm. T. B. C.

(Duration) yrs. 2D mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. J. Young M. D.

12/21, 191.. (Address) 1429 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Dec 23 1922

20-UNDERTAKER Chas. A. Johnson & Co. ADDRESS N. Carolina St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Spec.—1-10-21—M&T—1500 Blks.

D70266

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70266

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 Vine St ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Briscoe Turner

(a) RESIDENCE NO. 805 Vine St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 870

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Daniel Eaton (Address) 916 Pa ave

15 Filed DEC 21 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from December 2, 1922, to December 19, 1922, that I last saw her alive on December 18, 1922, and that death occurred, on the date stated above, at 2.10 A. m.

The CAUSE OF DEATH* was as follows:

apoplexy

Chronic Bright Disease (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bright Disease (duration) yrs. 4 mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. J. W. Kennard M. D.

12-19, 1922 (Address) 708 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Dec 22 1922

20 UNDERTAKER Daniel Eaton — ADDRESS 916 Pa ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70267

CERTIFICATE OF DEATH.

90 D70267

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 121 N. Fremont ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Pallhein

(a) RESIDENCE. NO. 121 N. Fremont ST., 4 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 6 mos. 27 ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Wm Pallhein

6 DATE OF BIRTH (month, day, and year) May 22 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Fenner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Fred Pallhein

(Address) 121 N. Fremont Ave

15 Filed DEC 21 1922, 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1922, to Dec 18, 1922, that I last saw h.. alive on Dec 18, 1922, and that death occurred, on the date stated above, at 9.40 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) ..... yrs. ..... mos. 13 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) H Hanna, M. D.

, 19 (Address) 1842 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemy — DATE OF BURIAL: Dec 22 1922

20 UNDERTAKER: J. S. Joesdens Son — ADDRESS: 217 S. Paca

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D70268

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2931 Walbrook Ave St. 15 WARD)

2-FULL NAME Elizabeth Feldman

(a) RESIDENCE. NO. 2931 Walbrook Ave St. WARD. 15th

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Henry Feldman

6 DATE OF BIRTH (month, day, and year) Jan. 13, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Schaeffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elmer R. Feldman

(Address) 2925 Walbrook Ave

15 Filed DEC 21 1922, 19— ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7th, 1922, to Dec. 19th, 1922, that I last saw her alive on Dec 19th, 1922, and that death occurred, on the date stated above, at 2.50 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis and Toxic Hypertension Senility (duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. Edgar Fay, M. D.

12/19 1922 (Address) 2919 Belmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Dec 22 1922

20 UNDERTAKER: Jos. Joerden & Son — ADDRESS: 2171 Rus

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS TO BE STATED EXACTLY. PHYSICIAN should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D70269

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D70269

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 N. Carrollton Ave St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winfred Grattle

(Residence in Baltimore: No. 920 N. Carrollton ave St.; 70 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	white	Married

6-DATE OF BIRTH, August 5 (Month), (Day), 1848 (Year)

7-AGE, 74 yrs. about 4 mos. 25 ds. | If LESS than 1 day, ...hrs./or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... house wife
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Roscommon Ireland

PARENTS.

10-NAME OF FATHER, Timothy Kelly

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Bridget Mitchell

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary O'Brown

(Address) Harford Rd & Orlando Ave.

15-

Filed....., 191..... Registrar.

ROBERT R. KRAMER
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 (Month) 20 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-10 1922, to 12-20 1922, that I saw h[er] alive on 12-19 1922, and that death occurred, on the date stated above, at 5.30a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis due to high blood tension

(Duration) 10 yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) X yrs. X mos. 10 ds.

(Signed) P. B. Wilson M. D.

12/20, 1922 (Address) 1124 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Leatherbark Cem. | DATE OF BURIAL, Dec. 14 1922

20-UNDERTAKER Martin Hughes & Son | ADDRESS 1827 N. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If UNDER ONE YEAR or OVER, the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

160391 D70270

CERTIFICATE OF DEATH.

101-001 D70270

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 6 WARD)

2-FULL NAME Lillian Askins.

(a) RESIDENCE NO. 1754 Mulligen St. City.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of Elizabeth (sister).

6 DATE OF BIRTH (month, day, and year) ?

7 AGE: Years 32 Months ? Days ? If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer) 〃 087

(c) Name of employer 〃

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER 〃

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alberta ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1922 to Dec. 19, 1922 that I last saw her alive on Dec. 19, 1922 and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) + otic Insufficiency of Cardiac Enlargement Myocardial Weakness

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of No

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. R. Bagg, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetary

DATE OF BURIAL Dec 24 1922

20 UNDERTAKER Jos. J. H. Rochester

ADDRESS 1413 E. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in giving information. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 1177 D70271

CERTIFICATE OF DEATH.

90 D70271

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Sydnor.

(a) RESIDENCE No. St. Elizabeth's Home, ST., Chestnut Hill Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE~~ of St. Elizabeth's Home.

6 DATE OF BIRTH (month, day, and year) Aug. 4, 1914.

7 AGE: Years 8 (8); Months 4 (4); Days 15. (15); If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pupil. 10

(b) General nature of industry, business, or establishment in which employed (or employer): (11.)

(c) Name of employer: (11)

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER James Sydnor

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER Annie Black,

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant JOHNS HOPKINS HOSPITAL Records. (Address)

15 DEC 21 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922 to Dec 19, 1922, that I last saw her alive on Dec 19, 1922, and that death occurred, on the date stated above, at 4.40 A. m.

The CAUSE OF DEATH* was as follows:

Chronic (Rheumatic) Endocarditis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Second Head Cem

DATE OF BURIAL Dec 21 1922

20 UNDERTAKER MR. & MRS. N. S. FINK, FUNERAL DIRECTORS

ADDRESS 1537 ~~1536~~ W. PRATT STREET.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in giving information. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70272

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D70272

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 S. Charles ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Steinbach

(a) RESIDENCE. NO. 929 S. Charles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should be careful in making their statements. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles P. Steinbach

6 DATE OF BIRTH (month, day, and year) Oct 22 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Mc Garry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant John E. Steinbach

(Address) 1142 Hanover st

15 Filed DEC 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1922, to Dec 18, 1922, that I last saw h alive on Dec 18, 1922, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. H. Campbell M. D.

Dec 19, 1922 (Address) 1644 Hanover st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Dec 22 1922

ADDRESS

20 UNDERTAKER Fred A Krause & Son 703 Hanover

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70273 CERTIFICATE OF DEATH. 16F-001 D70273

1-PLACE OF DEATH

CITY OF BALTIMORE: No. University Hospital St., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Ford

(a) RESIDENCE NO.... ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS MATTER IS IMPORTANT. PHYSICIANS should be careful in giving information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/18/22

7 AGE Years Months Days If LESS than 1 day, 5 hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) University Hosp. Balto Md.

PARENTS

10 NAME OF FATHER Orion Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Aberdeen Md

12 MAIDEN NAME OF MOTHER Elizabeth Schwartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Aberdeen Md

14 Informant (Address) Elizabeth Ford Aberdeen Md.

15 Filed DEC 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/19 19 22

17 I HEREBY CERTIFY, That I attended deceased from 12/18, 19 22, to 12/19, 19 22, that I last saw h[illegible] alive on 12/19, 19 22, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity (about 26 weeks)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Anthony V. Buchness, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 2 1922 19

20 UNDERTAKER Commissioner Health

ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

D70274

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70274

CERTIFICATE OF DEATH.

47

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 706 E. Eager ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olympia Beck

(a) RESIDENCE NO. 706 E. Eager ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Beck

6 DATE OF BIRTH (month, day, and year) Jan 23-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) Work

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) New York

PARENTS

10 NAME OF FATHER Anthony Hauser

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) France

12 MAIDEN NAME OF MOTHER Alberta Lenmonban

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) France

14 Informant Alberta Hauser
(Address) 706 E. Eager St.

15 DEC 21 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1922

I HEREBY CERTIFY, That I attended deceased from Sept 15 .1922. to Dec 20 .1922.

that I last saw h alive on Dec 19 .1922.

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Recurrent adeno Carcinoma of Ovary, Peritoneum

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 706 E Eager St

Did an operation precede death? Yes Date of June 1922

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) James M Reuling, M. D.

(Address) 1002 Cham St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec 23 1922

20 UNDERTAKER J. L. Riedefeld — ADDRESS 914 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D70275

D70275

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. William Lewis. St.: 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Little Sisters of the Poor.

(a) RESIDENCE. No. Preston & Valley Sts. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Link

6 DATE OF BIRTH (month, day, and year) April 11-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rope maker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Andrew B Lewis.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Harriet Schmick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Florence. (Address) Little Sisters of the Poor.

15 Filed DEC 21 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Record 19 to 19

that I last saw h/ alive on Dec 10 1922.

and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplectic convulsion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Dec 20 1922 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: Dec 22 1922

20 UNDERTAKER: W. C. Widefield

ADDRESS: 914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIAN'S NAME should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70276 129 D70276

REGISTERED NO.

D70276

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Scott St. ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna B. Schwartz

(a) RESIDENCE NO. 1315 Scott St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Schwartz

6 DATE OF BIRTH (month, day, and year) Sept. 4" 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	50	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Philip Kuhn

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Drechel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Mary M. Gough

(Address) 1637 Hanover St.

15 Filed DEC 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20" 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1922, to Dec 20, 1922, that I last saw h[illegible]ive on Dec 20, 1922, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ephanetas (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell M. D.

12/20 1922 (Address) 1644 S. Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL Dec 22, 1922

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 W. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS [illegible]. PHYSICIANS: [illegible] should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D70277

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70277

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2940 Winchester St. ST., 16 WARD)

2-FULL NAME Charles M. Haupt

(a) RESIDENCE NO. 2940 Winchester St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED OUT COMPLETELY. PHYSICIANS should be careful to obtain all information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth A. Haupt

6 DATE OF BIRTH (month, day, and year) Nov. 15" 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Mathias Haupt

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Granger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. E. V. Parlett
(Address) 2940 Winchester St.

15 DEC 21 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20" 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1922, to Dec 20, 1922, that I last saw h[illegible] alive on Dec 19, 1922, and that death occurred, on the date stated above, at 12.30A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(apoplexy)

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. O'Neill, M. D.

12/20 1922 (Address) 108 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Dec 22 1922

20 UNDERTAKER Jos B Cook — ADDRESS 603 N Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Klappler

75-001 D70278

D70278

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 N. Bradford ST.; 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Klappler

(Residence in Baltimore: No. 424 N. Bradford St.: 77 yrs.....mos.....ds.)

WRITE PLAINLY, WITH CARE. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widow

6-DATE OF BIRTH, Oct. 16 (Month) (Day), 1835 (Year)

7-AGE, 87 yrs. 2 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Georg Gebhardt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Gebhardt

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lena Endsmuder

(Address) 424 N. Bradford St.

15- Filed DEC 21 1922, 191... ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15 1921, to Dec 20 1922, that I saw h.. alive on Dec 13 1922, and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows:

Old age & complications

(Duration) 1 yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Hemiplegia (Duration) ... yrs. 8M mos. ... ds.

(Signed) Jos. M. H. Talkin M. D.

Dec 20, 1922 (Address) 22 E. Johnson St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL. Dec 23, 1922

20-UNDERTAKER J. Ullrich

ADDRESS 205 Eden

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70279

CERTIFICATE OF DEATH.

91-002 D70279

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 315 W. Monument ST.: 11 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Wilbur P. Morgan

(a) RESIDENCE. No. 315 W. Monument ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ BUSBAND of ~~(or) WIFE of~~ Lalage Morgan

6 DATE OF BIRTH (month, day, and year) 1840-2-23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	10	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) West Virginia
(State or country)

PARENTS

10 NAME OF FATHER Nicholas P. Morgan

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Phelps

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mrs. W. P. Morgan
(Address) 315 W. Monument

15 Filed DEC 21 1922 19 ROBERT S. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/20/22 19

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14th, 1922, to Dec. 20th, 1922, that I last saw him alive on Dec. 20th, 1922, and that death occurred, on the date stated above, at 11.20 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? ---------

Did an operation precede death? No Date of ------

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) George L. Shane, M. D.

12/21/22 (Address) 721 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: 12-22 1922

20 UNDERTAKER: Howard Jenkins & Sons Co

ADDRESS: Fulton & Lombard

Zaccari ✓

Spec.—1-10-21—M&T—1500 Bks.

D70280 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 101-001 D70280

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1826 E 28th ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank. Zaccari

(a) RESIDENCE NO. 1826 E. 28th ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Sol. Zaccari

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Angelina Cicero.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Sol. Zaccari
(Address) 1826 E 28 St.

15 Filed DEC 21 1922 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1922, to Dec 20 1922, that I last saw h[illegible] alive on Dec. 20, 1922, and that death occurred, on the date stated above, at 8.25 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. Fa Guinan, M. D.

12/21/1922 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Dec. 21 1922

20 UNDERTAKER Margaret D. Flynn — ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70281 576

CERTIFICATE OF DEATH. 100-00 / D70281

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 Alicanna ST. V WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Youngbuer

(a) RESIDENCE No. 1908 Alicanna ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13 1922

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) James Youngbuer

PARENTS

10 NAME OF FATHER Balto

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Stella Mazeranick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant James Youngbuer
(Address) 1908 Alicanna

15 Filed ..... 19 ..... Registrar

DEC 21 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 19 22 to Dec 20 19 22, that I last saw h[illegible] alive on Dec 19, 19 22 and that death occurred, on the date stated above, at 11 [illegible] m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) [illegible] M. D.

Dec 20 19 22 (Address) 60 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Dec 21 1922
20 UNDERTAKER	**ADDRESS**
Johnson Weber	1803 Bank

Spec.—1-10-21—M&T—1500 Bks.

D70282

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70282

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH South Baltimore Gen. Hospital

CITY OF BALTIMORE: (No. 1211 Light ST., W WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Kolakowski

(a) RESIDENCE NO. 432 S Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Constant Kolakowski

6 DATE OF BIRTH (month, day, and year) June 10 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Kolakowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Raymond Kolakowski 432 S Monroe

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 21 1922

17 I HEREBY CERTIFY, That I attended deceased from December 11, 19 22, 19 December 21, 19 22,

that I last saw her alive on December 21, 19 22,

and that death occurred, on the date stated above, at 12 40 9. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) John A. O'Connor M. D.

, 19 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Dec 23 1922

20 UNDERTAKER John M Weber — ADDRESS 1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 21 1922

Burial Permit Clerk.

Spec.—1-10-21 M&T 1500 Bks.

(Krzeczewski) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70283

D70283

90

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2035 Bank ST., 2 WARD)

2-FULL NAME Geo Krzeczewski

(a) RESIDENCE NO. 2035 Bank ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michael Krzeszewski

(Address) 2035 Bank St

15 Filed Dec 21 1922 Robert P. Carlson Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 19 22

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 19 22, to Dec 19, 19 22, that I last saw h... alive on Dec 19, 19 22, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Ryan M. D.

Dec 21, 19 22 (Address) 801 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL Dec 22 19 22

20 UNDERTAKER John Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIAN'S ... AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. ... that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ... is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70284 D70284

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1539 W. Lanvale (St.) 16 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian H. Hoare

(a) RESIDENCE. No. 1539 W Lanvale St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Hoare

6 DATE OF BIRTH (month, day, and year): Aug - 14 1870

7 AGE — Years: 52 Months: 4 Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: J. H. Kauffman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER: Matilda Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Woodbine Md

14 Informant: Frank Hoare
(Address) 1539 W Lanvale

15 Filed 19 Robert F. Carraher, Registrar
Burial Permit Clerk.

DEC 21 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12 - 19 1922

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1922, to Dec 19, 1922, that I last saw h alive on Dec 18, 1922 and that death occurred, on the date stated above, at 8.50 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia & Exhaustion (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 1922

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E Linton Oneill, M. D.

1924 (Address) 811 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 12/21 19

20 UNDERTAKER: W M Cook — ADDRESS: 502 E Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70285

101-00 D70285

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bessemer Ave. Graceland Park ST. 26 WARD)

2-FULL NAME. William J. A. Funk

(a) RESIDENCE. No. Bessemer Ave. Graceland Pk. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Margaret Funk

6 DATE OF BIRTH (month, day, and year) Aug 3-1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of Industry, business, or establishment in which employed (or employer) Iron work

(c) Name of employer Boston Iron & Metal Co.

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John F. Funk

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Kemmerzell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant John Funk (Address) Colgate Md.

15 Filed Dec 21 1922 Albert P. Harrison, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1922, to Dec 20, 1922, that I last saw him alive on Dec 20, 1922, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. W. Geier, M. D.

12/20. 1922 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	12/23rd 1922
20 UNDERTAKER	ADDRESS
William Cook	502 E North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70286 38 D70286

CERTIFICATE OF DEATH.

D70286 REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 Lyman Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry A. Sawkins

(Residence in Baltimore: No. 402 Lyman Ave St.; 1 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, November 4, 1865 (Month) (Day) (Year)

7-AGE, 57 yrs. 1 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work..... Salesman (b) General nature of industry, business, or establishment in which employed (or employer)..... do

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER. Fred A Sawkins

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Georgianna Whitely

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginia Sawkins

(Address) 38 Carrollton ave

15- Robert P. Harrison, Registrar.

Filed ....., 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 19, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1922, to Dec 19 1922, that I saw h.m alive on Dec 19 1922, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Tibes Anodes

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) yp

(Duration) yrs. mos. ds.

(Signed) Jno. H Hoofman M. D.

Dec 20, 1922 (Address) 5835 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cem

DATE OF BURIAL, Dec 22, 1922

20-UNDERTAKER George J Smith

ADDRESS 1532 Hollins

N.B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

DEC 22 1922 Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70287

CERTIFICATE OF DEATH.

47 D70287

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 N. Saratoga ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Emma Stewart

(a) RESIDENCE. No. 1801 N. Saratoga ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 9 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Henry Stewart

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md

PARENTS

10 NAME OF FATHER John Pierpont

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Naomi Widerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Elliott Balto. Co. Md

14 Informant Miss Maude Stewart (Address) 1801 N. Saratoga

15 Filed DEC 21 1922 Robert P. Garrison, Registrar

Burial Permit Issued

N. B.—WRITE PLAINLY, WITH CARBON PENCIL. AGE should be stated EXACTLY. The information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27th, 1922, to Dec. 20th, 1922, that I last saw her alive on Dec. 20th, 1922, and that death occurred, on the date stated above, at 3.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Carcinoma of rt. breast Metastasis to the liver

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) D. Edgar Fay, M. D.

12/21 1922 (Address) 2919 Belmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Dec 22 1922

20 UNDERTAKER George J. Smith

ADDRESS 1532 Hollins

William Woestmann

D70288

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70288

CERTIFICATE OF DEATH.

181-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 543 S Paca St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. William Worstermann

(Residence in Baltimore: No. 543 S Paca st St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. Nov (Month) 15 (Day) 1869 (Year)

7-AGE. 53 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Paper hanger
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Frank Worstermann

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Bety Keuckhoff

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. A Andrew

(Address) 6004 Breloud ave

15.

FEB 21 1922 Filed 1922 Robert P. Harrison, Registrar.

Burial Permit [illegible]

N.B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 20 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~inquest, autopsy or inquiry.)~~ find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation Stomachoy Tuo

(Duration) ... yrs. a few hours mos. ds.

CONTRIBUTORY (Secondary) Accidental

(Duration) ... yrs. ... mos. ... ds.

(Signed) W K Gordon M. D. (Coroner.)

12-21 1922 (Address) 1078 Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cemetery	Dec 22 1922
20-UNDERTAKER.	ADDRESS
Chas. J. Black	742 W. Pratt ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70289

91-00 D70289

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Dakin Ave ST., 9 WARD)

2-FULL NAME Mrs Martha Matthews

(a) RESIDENCE NO. 1 Dakin Ave ST., 27 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? ✓ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, ~~or divorced~~ HUSBAND ~~of~~ or WIFE of: William Matthews

6 DATE OF BIRTH (month, day, and year) ✓

7 AGE: Years: About 65 Months: Days: If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Baltimore Co Maryland

PARENTS

10 NAME OF FATHER: Amos Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Gorsuch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Wm E Jones
(Address): 1412 Washington

15 Filed ..... 19 ..... Robert F. Barrett Registrar

Chief Permit Clerk

DEC 21 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 19 1922

17 I HEREBY CERTIFY, That I attended deceased from ....., 1900 . to Dec 19 . 1922, that I last saw her alive on Dec 16 . 1922 and that death occurred, on the date stated above, at 5, 45P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. mos/4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) William F Todd, M. D.

, 19 (Address) 1412 Washington Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Dec 23 1922

UNDERTAKER: Horace A. Burgee — ADDRESS: 363 Pulaski Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED EXACTLY. PHYSICIANS should mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D70290 HEALTH DEPARTMENT—CITY OF BALTIMORE D70290

CERTIFICATE OF DEATH. Registered No. C 179

1-PLACE OF DEATH U. P. S. ~~54 Lamont~~ St., 14 Ward)

City of BALTIMORE: (No. ~~54~~) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Newton

(Residence in Baltimore: No. 511 Lamont St. St.; yrs., 9 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. March 7, 1919 (Month) (Day) (Year)

7-AGE. 3 yrs. 9 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work none (child)

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Howard Newton

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Annie Dow

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Newton

(Address) 511 Lamont St

15- Robert P. Harrison, Registrar.

DEC 21 1922 Burial Permit Dist.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 9, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st. degree burns of body.

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) night gown caught fire from gas stove.

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hammond M. D. (Coroner.)

Dec. 26, 1922. (Address) 700 E. Lanvale St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cmty. DATE OF BURIAL. 12-22-1922

20-UNDERTAKER George A. Gibson ADDRESS 513 Lamont St

NB.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70291

CERTIFICATE OF DEATH.

X90

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

CITY OF BALTIMORE: (No. FT. MCHENRY, BALTO., MD. ST. 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME TASSO, George

(a) RESIDENCE No. 73 West St., Annapolis, Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Married, Widow, or Widower
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) -- 030

(c) Name of employer --

9 BIRTHPLACE (city or town) -- (State or country) Greece

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) -- (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) -- (State or country) Unknown

14 Informant Hospital Records

(Address) Fort McHenry, Balto., MD.

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1922.

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1922, to December 21, 1922, that I last saw him alive on December 21, 1922, and that death occurred, on the date stated above, at 3:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

- (duration) - yrs. - mos - ds.

CONTRIBUTORY (Secondary) Hypertension Arterial

- (duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & clinical history.

(Signed) A D Luse, M. D.

12/21 1922 (Address) Surgeon (R) Ft. McHenry, Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md.

DATE OF BURIAL 12/21 1922

20 UNDERTAKER. A. Lemmon & Bro

ADDRESS 411 E. Balto St.

DEC 21 1922

B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70292 D70292 129

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 John ST., 14 WARD)

2-FULL NAME Arthur Stockdale

(a) RESIDENCE NO. 1510 John ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 3 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	52	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner 073

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penna R.R.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Stockdale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Mrs. Annie Morgan 1510 John St.

15 Filed ... 19 ... Registrar Robert F. Harrison

Burial Permit Clerk.

DEC 21 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1922, to Dec 21, 1922, that I last saw h alive on Dec 20, 1922, and that death occurred, on the date stated above, at 5-20 A m.

The CAUSE OF DEATH was as follows:

Acute Cardiac Dilitation

(duration) ... yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Paul Brown M. D.

12-21, 1922 (Address) 1837 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lutheran Cemetery Reisterstown

DATE OF BURIAL Dec 23 1922

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1924 W. North

B.—WRITE PLAINLY, WITH UNFADING INK. This information should be stated EXACTLY. PHYSICIANS should be careful in filling out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70293

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70293

CERTIFICATE OF DEATH.

45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2707 W. North Ave. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Wise Zollinger

(a) RESIDENCE NO. 2707 W. North Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N.B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. See instructions on back of certificates

Spec.—1-10-21—M&T—1500 Blks.

+ Had been ill one week before I saw her

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70294

74-001 D70294

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 237 N. Luzerne St. ST., 6 WARD)

2-FULL NAME Ella Amanda Mitchell

(a) RESIDENCE NO. 237 N. Luzerne St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~ or ~~Divorced~~, Widowed, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph T. Mitchell

6 DATE OF BIRTH (month, day, and year) Nov. 1" 1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Freeburger

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Jane Brown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant Mrs. Louis Ullman

(Address) 560 W. 182nd St. New York

15 Filed ..... 19 ..... Robert P. Garrison, Registrar

Burial Permit Issued.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIAN should be careful and supplied. AGE should be stated EXACTLY. PHYSICIAN should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 21 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12th, 1922, to Dec. 20, 1922+ that I last saw h[illegible] alive on Dec. 20, 1922, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (and long existing Arterio-sclerosis)

Pneumonia about (duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? In Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) Robert W. Mifflin, M. D.

12/20 1922 (Address) No 1016 Madison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Dec 23" 1922

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 W. Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D70295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

D70295

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Oliver

(Residence in Baltimore: No. 631 S. Decker Ave. St.; 40 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, July 3rd, 1878
(Month) (Day) (Year)

7-AGE, 44 yrs. 5 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), New York City.

PARENTS.

10-NAME OF FATHER, Thomas H. Williamson

11-BIRTHPLACE OF FATHER (State or Country), Penna.

12-MAIDEN NAME OF MOTHER Elenora McDermott

13-BIRTHPLACE OF MOTHER (State or Country), Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert W. Oliver

(Address) 631 S. Decker Ave.

15- DEC 22 1922 Filed....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 21, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 14 1922, to December 21 1922, that I saw h[illegible] alive on December 21 1922, and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetis Coma

.....

.....

..... (Duration).....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration).....yrs.....mos. 3 ds.

(Signed) Moses Gellman M. D.

Dec. 21, 1922. (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? At home.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park. DATE OF BURIAL, Dec. 24, 1922.

20-UNDERTAKER Lilly & Zeller ADDRESS 403 S. Wolfe.

N. B.—Every item of information should be carefully supplied. AGE must be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70296

CERTIFICATE OF DEATH.

129 D70296

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 S. East Ave. St.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Magdelana Fischer

(Residence in Baltimore: No. 711 S. East ave. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June 29th (Month) (Day), 1845 (Year)

7-AGE, 77 yrs. 5 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, John Edgdallotte

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Metzger

(Address) 711 S. East Ave

15- Filed DEC 22 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 19th (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1922 to Dec 19 1922 that I saw her alive on Dec 18 1922, and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Chronic Glumerulitis
Nephritis
(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis
(Duration) yrs. mos. 7 ds.

(Signed) Frances P. Teller M. D.

12-20, 1922 (Address) 315 S. Highland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, Dec 22nd 1922

20-UNDERTAKER Lilly Zeiler ADDRESS 4038 Wolfe

N. B.—Every item of information should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70297

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D70297

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2508 East Madison ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Knueppel

(a) RESIDENCE No. 2508 East Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hubert Knueppel

6 DATE OF BIRTH (month, day, and year): Oct 10/1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nation Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Peter Jaeger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Albert P. Schmidt

(Address) 2128 North Wolfe St

15 Filed DEC 22 1922 ROBERT R. KRAUTER, Register

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 19 — 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922 to Dec 19 1922,

that I last saw h alive on Dec 19, 1922,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion + Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma 7

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exhaustion

(Signed) Claus Jensen, M. D.

(Address) 4 706 Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery Co

DATE OF BURIAL: 12/22/ 1922

20 UNDERTAKER: Geo Weber & Son

ADDRESS: 2503 Edmondson Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D70298

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Benison

(a) RESIDENCE. NO. 623 W. Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 10 1921

7 AGE: Years 1 Months 11 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Shields Benison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Fannie King

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: F. King (Address) 623 W. Mulberry St

15 DEC 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 1922 to Dec 20 1922, that I last saw him alive on Dec 20 1922, and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria nasal, tonsillar, pharyngeal & laryngeal

(duration) — yrs. — mos. 20 ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) — yrs. — mos. 16 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no What test confirmed diagnosis? Culture (+)

(Signed) B. MacSwain, M. D.

12/21/22 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn Cemetery	12/22 '22
20 UNDERTAKER	ADDRESS
R L Parlour H	220 Hamburg St

N. B.—WRITE PLAINLY, WITH LAWFUL INK. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70299

CERTIFICATE OF DEATH.

57

D70299

REGISTERED NO.

1-PLACE OF DEATH Lake Drive & Lakeview Ave.,

CITY OF BALTIMORE: (NO. Saville Apartments ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie Lesser

(a) RESIDENCE NO. Saville Apartments ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Louis Lesser

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Norman Spandall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1437 E Baltimore

15 Filed DEC 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1920 to Dec. 21, 1922, that I last saw h[illegible] alive on Dec 21, 1922, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombus

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus, Myocarditis

Arteriosclerosis (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Reador H. Morrison M. D.

12/24, 1922 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL 12/27/1922

UNDERTAKER Jack Lewis ADDRESS 1439 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS' information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70300

99-801

D70300

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 N. Longwood ST.: 18 WARD)

2-FULL NAME Esther J. Taylor

(a) RESIDENCE. No. 1105 N. Longwood ST., 18 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Taylor

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Ireland

14 Informant William C. Taylor (Address) 1105 N. Longwood St.

15 Filed DEC 22 1922 19 ROBERT R. KRAUTH Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/20/22 19

17 I HEREBY CERTIFY, That I attended deceased from 11/10/22, 19, to 12/20/22, 19, that I last saw h.. alive on 12/17/22, 19, and that death occurred, on the date stated above, at 3.00 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Exhaustion
Old age.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchitis acute (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) [illegible] M. D.

12/21, 1922 (Address) 1302 N. Longwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Dec 22 1922
20 UNDERTAKER John J. Conway Son	ADDRESS 901 Hollins St

N. B.—WRITE PLAINLY. WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN should be careful to see that information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 129

D70301

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Charles Walker

(a) RESIDENCE NO. 151 East St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Neurik Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Maryland

14 Informant Municipal Hospital Records. (Address)

15 FILED DEC 22 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1922, to Dec. 20, 1922, that I last saw h alive on December 20, 1922, and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Clyde M. Snell M. D.

12/21/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery DATE OF BURIAL Dec 24 1922

20 UNDERTAKER Chris H. Johnson ADDRESS 416 N Caroline St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D70302

CERTIFICATE OF DEATH.

D70302

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 Cording Ave ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lydia H. Batton

(Residence in Baltimore: No. 511 Cording Ave - (Govans St.; 12 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Aug (Month) 29 (Day), 1862 (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..at Home..
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, — Mandsley

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Cynthia Crouch

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Meyer

(Address) 511 Cording Ave

15-

Filed DEC 22 1922, 191... ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec (Month) 20 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11 1922, to Dec. 20 1922, that I saw h[er] alive on Dec. 20 1922, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Double)

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. C. Hoen M. D.

12-21-, 192- (Address) 2900 Yuke Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet

DATE OF BURIAL, Dec. 23, 1922

20-UNDERTAKER Lowe Cook

ADDRESS 502 E Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70303

CERTIFICATE OF DEATH.

129V D70303

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Kleff

(a) RESIDENCE. No. 1834 Walbrook ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Gertrude Kleff

6 DATE OF BIRTH (month, day, and year) Nov 18 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hochschild Kohn & Co

086

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Arnold Kleff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Voshell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Mr Arnold Kleff

(Address) 2808 Wordell Ave

15 Filed DEC 22 1922 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/22 1922

17 I HEREBY CERTIFY, That I attended deceased from 9/25, 1922, to 12/22, 1922, that I last saw h(er) alive on 12/22, 1922 and that death occurred, on the date stated above, at 1.25 A.m.

The CAUSE OF DEATH* was as follows:

Aortic regurgitation & chronic Nephritis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Milton C. Lang, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Smyrna Del

DATE OF BURIAL 12/23 1922

20 UNDERTAKER William Cook

ADDRESS 502 E Fayette Ave

N. B.—WRITE PLAINLY, WITH CARBON PENCIL. AGE should be stated EXACTLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION of deceased should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70304

167-001

D70304

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Phila. Road + 15th St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Armida Herman Ulbrg

(Residence in Baltimore: No. Phila Road + 15th St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Nov. (Month) 2nd (Day) 1922 (Year)

7-AGE: ..... yrs. 7 Weeks mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Infant (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Phila Road + 15th St

PARENTS.

10-NAME OF FATHER: Herman A Ulbrg

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary B. Baker

13-BIRTHPLACE OF MOTHER, (State or Country): Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman A Ulbrg

(Address) Phila Road + 15th St

15-

Filed ..... 192. ROBERT R. KRAUTER, Registrar.

DEC 22 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 21st (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition

7 weeks (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature Birth

About 7½ mos (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D. (Coroner)

Dec 21st 1922. (Address) Curtis Bay Md

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park DATE OF BURIAL: Dec 22 1922

20-UNDERTAKER: Wm Cook ADDRESS: 502 E Lee

N. B.—Every item of information should be carefully supplied. All items must be properly classified. Exact statement of occupation should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70305

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

129 D70305

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 245 W Biddle St (St.) 27 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Louise Dennis

(a) RESIDENCE. (No.) Charles & Bellona Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 21 1885

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Upshur Dennis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Somerset County Md

12 MAIDEN NAME OF MOTHER Frances A Murdock

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Mississippi

14 Informant Murdock Dennis
(Address) Bellona & Charles St Ave

15 Filed ..., 19...
DEC 22 1922
Robert R. Krauer
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/20 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1922, to Dec 20, 1922, that I last saw h. alive on Dec 20, 1922, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rosacea

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory & Clinical findings

(Signed) [illegible], M. D.

12/21/1922 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Dec 22 1922
20 UNDERTAKER	ADDRESS
Henry J Jenkins & Son Co	Edmondson Ave-Catonsville

N. B.—WRITE PLAINLY, with ink. All items must be stated. AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70306

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70306

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 Park Ave ST.: 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Spence Butler

(a) RESIDENCE. NO. 823 Park Ave ST. 11 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ ~~(or WIFE)~~ of Oliver Nathaniel Butler

6 DATE OF BIRTH (month, day, and year) March 19 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Norfolk Virginia
(State or country)

PARENTS

10 NAME OF FATHER William Wallace Spence

11 BIRTHPLACE OF FATHER (city or town) Edenborough
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Ann Windley

13 BIRTHPLACE OF MOTHER (city or town) Norfolk
(State or country) Virginia

14 Informant Borrow Van Ness
(Address) 823 Park Ave.

15 Filed DEC 22 1922 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct ..., 19 22, to Dec 19 ..., 19 22,
that I last saw h... W... alive on Dec 19 ..., 19 22,
and that death occurred, on the date stated above, at 4 30 A m.
The CAUSE OF DEATH* was as follows:

Carcinoma Stomach (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach (duration) ... yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Pathological Findings

(Signed) H Warren Buerlein, M. D.

Dec 20, 19 22 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Dec 22 1922
20 UNDERTAKER	ADDRESS
John B. Spence	1328 N. Caroline St

N. B.—WRITE CLEARLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec. 1000 Bks.

D70307

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70307 1922 49 1873

CERTIFICATE OF DEATH.

129 V 15

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1364 N Stricker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie L Wood

(a) RESIDENCE. NO. 1364 Stricker ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John R. Wood.

6 DATE OF BIRTH (month, day, and year) July 14, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work, 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self. St Marys Co,

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co

12 MAIDEN NAME OF MOTHER Drucilla Seebert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co

14 Informant Carrie Green (Address) 1364 Stricker St

15 Filed DEC 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1922

17 I HEREBY CERTIFY, That I attended deceased from November 3, 1922, to Dec 21, 1922, that I last saw h[er] alive on Dec 20, 1922, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 6 mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exa

(Signed) William A Wright M. D.

19 22 (Address) 120 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns Cemetery Somerset Co Md

DATE OF BURIAL: Dec 23 1922

20 UNDERTAKER: Clarence Coolidge

ADDRESS: 1864 Park Ave

N. B.—WRITE PLAINLY, with ink. All items must be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70308 HEALTH DEPARTMENT—CITY OF BALTIMORE D70308

CERTIFICATE OF DEATH. 44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2916 Harford Rd ST.: 9 WARD)

2-FULL NAME James A Bond

(a) RESIDENCE. (Usual place of abode) No. 2916 Harford Rd ST., ... WARD. .....

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie B. Bond

6 DATE OF BIRTH (month, day, and year): May 22 1849

7 AGE: Years 73 Months 6 Days 27

If LESS than 1 day, hrs. or min. ...

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Captain 086

(b) General nature of industry, business, or establishment in which employed (or employer): Sailing Vessels

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co. Md

PARENTS

10 NAME OF FATHER: John Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cecil Co. Md

12 MAIDEN NAME OF MOTHER: Mary Elizabeth Chard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cecil Co. Md

11 Informant (Address): Mary E. Lawton 2916 Harford Rd

15 DEC 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 21 1922 to Dec 19 1922

that I last saw him alive on Nov 16 1922,

and that death occurred, on the date stated above, at 5-30 p.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Left Mandibular Bone & Resophagus

(duration) 1 yrs. 5 mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of Nov 7. 1921 13 months ago

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) H. Leonard Hood, M. D.

12-22-22 (Address) 5108 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pasadena A.G.Co.	Dec 22 1922
20 UNDERTAKER	ADDRESS
A. Sander & Sons	1710 Fleet St

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
be properly classified, so that it may be
CAUSE OF DEATH in plain terms,
of certificates. See instructions on back of cer-
TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

15 9652 8 15 P D70309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 D70309

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clemmer R. Howard

(a) RESIDENCE NO. 2607 W. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 19-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Benj Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ida Conda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address) ROBERT R. KRAUTER, BURIAL PERMIT CLERK

15 DEC 22 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 11 -, 1922, to Dec 20, 1922, that I last saw he alive on Dec 20, 1922, and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

General Miliary Tuberculosis

(duration) yrs. mos 45 ds.

CONTRIBUTORY (Secondary) Tuberculous Meningitis (duration) yrs. mos. 40 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy.

(Signed) Horton Caspares, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL Dec 22 1922

20 UNDERTAKER W. J. Ecker & Sons ADDRESS W Pa

N. B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70310 D70310

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 S Paca ST., 22 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vilova Vaskevicus

(a) RESIDENCE No. 629 S Paca ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of - - -

6 DATE OF BIRTH (month, day, and year) Nov. 21th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work - - - -

(b) General nature of industry, business, or establishment in which employed (or employer) - - -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore MD.

PARENTS

10 NAME OF FATHER Antanas Vaskevicus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER C. Kunigonis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore MD.

14 Informant Antanas Vaskevicus

(Address) 629 S Paca Street

15 Filed DEC 22 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 21th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 21, 1922, that I last saw h-r alive on Dec 21, 1922, and that death occurred, on the date stated above, at 7th P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) ..... yrs. ..... mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms and Course

(Signed) [illegible], M. D.

12 21 1922 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Dec. 23th 1922
20 UNDERTAKER	**ADDRESS**
John Grebliauckas	425 S Paca St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Enteritis
also Teething

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70311 49 D70311

D70311

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wildy

(a) RESIDENCE NO. 2128 Brunt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
56	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Wildy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records. (Address)

15 Filed DEC 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 19 22

17 I HEREBY CERTIFY, That I attended deceased from December 20 19 22, to December 21 19 22, that I last saw him alive on December 21, 19 22, and that death occurred, on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clyde Mitchell M. D.

12/21/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va

DATE OF BURIAL Dec 24 1922

20 UNDERTAKER James A. Dennis

ADDRESS 303 Greatmans

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY

D70312
Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70312

CERTIFICATE OF DEATH.

+ 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 Cove Alley ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Barnes

(a) RESIDENCE NO. 229 Cove Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Known

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE — Years: 90? — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nil

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Franklin Co Pa

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Georgie E. Smith

(Address): 229 Cove St.

15 Filed DEC 22 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/29 1922

17 I HEREBY CERTIFY, That I attended deceased from 9/25 1922 to 12/20 1922

that I last saw him alive on 12/29 1922

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Valvulitis

(duration) Indefinite mos

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Ordinary

(Signed) W. H. Rodell M. D.

1922 (Address) 1191 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — DATE OF BURIAL: Dec 22 1922

20 UNDERTAKER: James F. Dennis — ADDRESS: 303 Greatmead

N. B.—WRITE PLAINLY, with ordinary pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70313 CERTIFICATE OF DEATH. 90 D70313

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Marshall

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1349

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
73	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fisherman 86

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER George Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Martha Needham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Municipal Hospital Records. (Address)

15 Filed DEC 22 1922 ROBERT R. KRAUER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 19 22, to December 18 19 22, that I last saw him alive on December 17, 19 22, and that death occurred, on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Auricular fibrillation

(duration) 2 yr. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Electrocardiograph etc

(Signed) Clyde Brown M. D.

(Address) Municipal Hospital. 12/20/22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

DEC 2 1922

1575.3

Spec.—1-10-21—M&T—1500 Blks.

Retmug ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

1602 12 Med D70314

CERTIFICATE OF DEATH.

+101-00 D70314

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME Norris Retmug

(a) RESIDENCE NO. Bradston Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 Yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 10 - 1868

7 AGE: Years 54 | Months 4 | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm. Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed DEC 22 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1922 to Dec 15, 1922.

that I last saw him alive on Dec 15, 1922.

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical & Laboratory

(Signed) Chas. LeBrun, M. D.

, 19 (Address) Johns Hopk. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Burdnest Va — DATE OF BURIAL: Dec 22 1922

20 UNDERTAKER: Joseph ahrens — ADDRESS: 22 Bway

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70315

D70315

129

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3708 E. Lombard ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. Tierney

(a) RESIDENCE NO. 3708 E. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Tierney

6 DATE OF BIRTH (month, day, and year) Jan. 2-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Employee of B. & O. R.R. Co.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer :

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas A. Tierney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant (Address) Kate Tierney 3708 E. Lombard St.

15 DEC 22 1922 . 19 Robert F. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1919 to Dec 21, 1922

that I last saw him alive on Dec 20, 1922

and that death occurred, on the date stated above, at 10. A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation Symptoms

(Signed) Clarence B. Fisher M. D.

12/22 1922 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem.

DATE OF BURIAL Dec. 23 1922

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Woll St

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Information should be stated EXACTLY. Information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70316

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70316

CERTIFICATE OF DEATH.

X 31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 W Mulberry ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Der Hay

(a) RESIDENCE. NO. 209 W. Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? 2 yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Chinese	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20 4/12			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundryman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) China

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant

(Address)

Filed DEC 22 1922

Robert J. Harrigan, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 18th, 1922, to Dec. 20th, 1922, that I last saw h(e) alive on Dec. 18th, 1922, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emma R Brown, M. D.

Dec. 20, 1922 (Address) 1223 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 23 1922
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH CARE and PENCIL. AGE should be stated EXACTLY. Exact statement of occupation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70317

CERTIFICATE OF DEATH.

D70317

1-PLACE OF DEATH

REGISTERED NO. C 31

CITY OF BALTIMORE: (No. 735 Cumberland St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. T. Benson.

(Residence in Baltimore: No. 735 Cumberland St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, June 12, 1922 (Month) (Day) (Year)

7-AGE, yrs. 6 mos. 10 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Chas H Benson

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER Margaret Briggs.

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas H Benson

(Address) 735 Cumberland St.

15-

Filed Robert F [illegible], 191

Registrar.

DEC 22 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 22, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 17th 1922 to December 22 1922, that I saw him alive on Dec. 21st 1922, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank N. Hillis M. D.

Dec 21, 1922 (Address) 2838 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park. DATE OF BURIAL, Dec 22, 1922

20-UNDERTAKER, Woolbrook. ADDRESS 502 E. Madison

WRITE.—Every item of information should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70318

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70318

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 Willow Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry P. Becker

(a) RESIDENCE NO. 709 Willow Ave, Govans ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen E. Becker

6 DATE OF BIRTH (month, day, and year): Aug 2. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Helen E. Becker

(Address): 709 Willow Ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

DEC 22 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 22 1922

17 I HEREBY CERTIFY, That I attended deceased from December 19 1922 to Dec 22 1922

that I last saw him alive on Dec 21 1922

and that death occurred, on the date stated above, at 4.50 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) S W Brady M. D.

Dec 22 1922 (Address) 501 Sheldon Ct

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Cemetery — DATE OF BURIAL: 12/28 1922

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Nor

NOTE.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D70319 HEALTH DEPARTMENT—CITY OF BALTIMORE D70319

CERTIFICATE OF DEATH. 188-003

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. U. O. I. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Greenbaum

(Residence in Baltimore: No. 2811 Rockrose Ave. St.; 61 yrs. 10 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word): Married

6-DATE OF BIRTH: Feb. 9, 1861 (Month) (Day) (Year)

7-AGE: 61 yrs. 10 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Clothing

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Isaac Greenbaum

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Minna Frank

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Greenbaum

(Address) 2811 Rockrose Ave.

15- Filed DEC 22 1922 Robert P. Harrison, Registrar. (Burial Permit Clerk.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 21, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of right leg.

(Duration) ....yrs. ....mos. 27 ds.

CONTRIBUTORY (Secondary) Automobile Accident

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Hennessy M. D. (Coroner.)

Dec 21 1922 (Address) 2502 Edmondson Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto. Hebrew Cem. DATE OF BURIAL, 12/24/1922

20-UNDERTAKER, David Sondheim ADDRESS 115 W. Mt Royal Ave

N. B.—Every item of information should be carefully supplied. Exact statement of occupation is very important. See instructions on back of certificate.

DEC 22 1922

Spec.—1-10-21—M&T—1500 Bks.

D70320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70320

86

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore General Hospital

CITY OF BALTIMORE: (No. 121 Light ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret McNaney

(a) RESIDENCE NO. 1252½ Riverside Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph McNaney

6 DATE OF BIRTH (month, day, and year) [illegible] 1876

7 AGE Years 46 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. 0.37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Schmidt

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Loretta Schmuck Daughter

(Address) 1252 Riverside Ave

15 Filed DEC 22 1922, 19 Robert P. Harrison, Registrar

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 20 1922

17 I HEREBY CERTIFY, That I attended deceased from December 19, 1922 to December 20, 1922 that I last saw her alive on December 20, 1922, and that death occurred, on the date stated above, at 1209 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) John A. O'Connor M. D.

, 19 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 12/22 19 22

20 UNDERTAKER [illegible]

ADDRESS 1815 Light

N. B.—WRITE PLAINLY with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. Attention is called to the importance of correctly stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70321

CERTIFICATE OF DEATH.

1/29 D70321

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1400 Druid Hill Ave ST. WARD)

2-FULL NAME Sarah Carey

(a) RESIDENCE. No 1400 Druid Hill Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) John Carey

6 DATE OF BIRTH (month, day, and year) ? - 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Burgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Nellie Mc Glynn

(Address) 615 N Charles St.

15 Dec 22 1922 Robert P. Harper, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1922, to Dec 21, 1922, that I last saw h[illegible] alive on Dec 21, 1922, and that death occurred, on the date stated above, at 8 20 a. m.

The CAUSE OF DEATH* was as follows:

Chr Int Nephritis

Bronchial Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas P Clautice M. D.

Dec 21 1922 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 12/23 1922

20 UNDERTAKER J J Gahagan & Sons — ADDRESS 518 Park Ave

R. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in YEARS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D70322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7 × 31 D70322

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 915 N. Carolina St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah A. Buckley

(Residence in ~~Baltimore:~~ No. Municipal Hospital St.; yrs. (1 mos.) ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced. (Write the word) Widow

6-DATE OF BIRTH. Jan (Month) 20 (Day) 1850 (Year)

7-AGE. 72 yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Western Md.

PARENTS.

10-NAME OF FATHER. John Wells

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Catherine Grassaway

13-BIRTHPLACE OF MOTHER. (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Rango Ford

(Address) Municipal Md.

15- Filed ..... 192.... Robert P. Harrison, Registrar.

DEC 22 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 22 (Day) 192.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, au inquiry (topsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Probably Tuberculosis)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Organic Heart ?

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Walter M. D.

12-22 192 (Coroner) (Address) 508 E Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence. Municipal Md

19-PLACE OF BURIAL OR REMOVAL. Munkirk Md — DATE OF BURIAL. 12-24 192

20-UNDERTAKER. Geo. E. French — ADDRESS Laurel Md

N.B.—Every item of information should be carefully supplied. Exact state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate is very important.

Spec.—1-10-21—M&T—1500 Bks.

D70323

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70323

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3938 Edmondson ST., 16 WARD)

2-FULL NAME Margaret E. Lutman

(a) RESIDENCE NO. 3938 Edmondson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced? (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John A. Lutman

6 DATE OF BIRTH (month, day, and year): June 25 1862

7 AGE — Years: 60 — Months: 5 — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

137

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Patrick Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ire.

12 MAIDEN NAME OF MOTHER: Bridget MacBrearty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ire.

14 Informant (Address): Wm. E. Lutman 3938 Edmondson Ave.

15 Filed ..... 19 ..... Registrar

Robert F. Harrison,
Burial Permit Clerk.

C 22 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1921, to Dec 21 1922, that I last saw her alive on Dec 21 1922, and that death occurred, on the date stated above, at 12 40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas L Mansfield, M. D.

19 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 12/23/19 22

20 UNDERTAKER: J. A. J. Moran

ADDRESS 3000 E. Baltimore

C. B.—WRITE PLAINLY, with pencil or pen and ink. All items must be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70324

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 602 S. Curley ST.; 1 WARD)

2-FULL NAME George Washington Phelps.

(a) RESIDENCE. NO. 602 S. Curley ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Phelps.

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jonathon Phelps

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Miss — Donaldson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant (Address) Mrs William Bergen 602 S. Curley St

15 Filed DEC 22 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 20th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 5th, 1922, to Dec 20th, 1922, that I last saw him alive on December 19th, 1922, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Dr Conrad Seidel, M. D.

19 (Address) 1900 Maryland ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys (Hampden)	Dec 23 19 22
20 UNDERTAKER	ADDRESS
E. LeRoy Stiffler	125 E. NORT

NOTE.—Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be important. See instructions on back of certificates.

D70325

HEALTH DEPARTMENT---CITY OF BALTIMORE

D70325

CERTIFICATE OF DEATH

161-002

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Willow Ave. St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby of Dwight Dr. & Julianna E. Burroughs

(Residence in Baltimore: No. 8 Willow Ave. St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, (DIVORCED), (Husband or Wife of ..... living or dead)

6-DATE OF BIRTH: 12 (Month) 22 (Day), 1922 (Year)

7-AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day ..... hrs., or 2 min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
None

9-BIRTHPLACE (State or country)
8 Willow Ave.

PARENTS

10-NAME OF FATHER: Dwight D. Burroughs

11-BIRTHPLACE OF FATHER (State or country): Balto

12-MAIDEN NAME OF MOTHER: Virginia E. Pickett

13-BIRTHPLACE OF MOTHER (State or country): Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dwight D. Burroughs

(Address) 8 Willow Ave

15-

Filed 191

Robert P. Harrison,
Burial Permit Clerk.
REGISTRAR

DEC 22 1922

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 12 (Month) 22 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ..... 191 ..... to ..... 191 ....., that I saw h..... alive on 12/22 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to Placenta Praevia

(Duration) ..... yrs ..... mos. ..... ds.

Contributory (SECONDARY)

(Duration) ..... yrs ..... mos. ..... ds.

(Signed) Henry Russell M D

12/22 ....., 19 22 (Address) 3402 Greenmount

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Leigh Cem.

DATE OF BURIAL: 12/25 1922

20-UNDERTAKER: Robt S. Lisle

ADDRESS: 2 Edmondson Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in each case. In stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D70326

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70326

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Corey.

(a) RESIDENCE NO. 616 Park Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 19 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land

PARENTS

10 NAME OF FATHER James Corey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mary Land

12 MAIDEN NAME OF MOTHER Sara Edelen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mary Land

14 Informant (Address) Mercy Hospital

Filed Dec 22 1922, 19 Robert F. Duffield, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1922, to Dec 22, 1922

that I last saw her alive on Dec. 20, 1922

and that death occurred, on the date stated above, at 2.20 P.M.

The CAUSE OF DEATH* was as follows:

Fracture of Tuberosity of Humerus

Dislocated L. Shoulder

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Bronchi-Pneu

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12/21/22

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam. & X Ray

(Signed) F. J. Sandoz M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 12/25/22

20 UNDERTAKER Geo. W. Finley

ADDRESS Fulton & Fayette

N.B.—WRITE PLAINLY, WITH INK. ... AGE should be stated EXACTLY. ... mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

22 1922

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

accidentally
Injured cord neg in fall
W. L. [illegible]
[illegible]

Spec.—1-10-21—M&T—1500 Bks.

1568504 5 45 BD D70327

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 90 D70327

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Johns Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Van Stavern

(a) RESIDENCE NO. Admiral Blvd Dundalk Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of John Van Stavern

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address)

15 Filed . 19 Registrar

DEC 22 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 - 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 19 - 1922 to Dec 22 1922

that I last saw her alive on Dec 22 1922

and that death occurred, on the date stated above, at 5 40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency -

OWL

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Gangrene left leg -

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Dundalk -

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) S Davis Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Falcon rest Va — DATE OF BURIAL 23 1922

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 B Way

N. B.—WRITE PLAINLY with pen and ink. All information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Ms Diabetes

Spec.—1-10-21—M&T—1500 Blks.

D70328

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70328

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 442 E. Cross ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J. Burke

(a) RESIDENCE NO. 442 E. Cross ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Burke

6 DATE OF BIRTH (month, day, and year) June 30, 845

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Henry Burkey

11 BIRTHPLACE OF FATHER (city or town) Balto, Md. (State or country)

12 MAIDEN NAME OF MOTHER Jennie Cables

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md. (State or country)

14 Informant Laura Edmond (Address) 442 E. Cross St.

15 Filed DEC 23 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1922, to Dec 21, 1922, that I last saw h[illegible] alive on Dec 21/22, 19[illegible], and that death occurred, on the date stated above, at 6.20 m.

The CAUSE OF DEATH* was as follows:

Paralysis (Hemiplegia) 6th

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B. Holl, M. D.

Dec 23/22 (Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL Dec 23 1922

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light St.

N.B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"): *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplexie

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70329 D70329

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Woodlea Place ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha E. Calvert

(Residence in Baltimore: No. 2 Woodlea Place St.; 30 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Aug (Month) 29 (Day), 1846 (Year)

7-AGE, 76 yrs. 3 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Carroll Co, Md

PARENTS.

10-NAME OF FATHER, Wm. Frizzell

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co, Md

12-MAIDEN NAME OF MOTHER Catherine Lindsay

13-BIRTHPLACE OF MOTHER (State or Country), Carroll Co, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Frederick Frailer

(Address) 2 Woodlea Place

15-

Filed..... Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 22 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 18 1922, to Dec 22 1922, that I saw h alive on Dec 18 1922, and that death occurred, on the date stated above, at 10 a.m. p

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Bronchial asthma (Duration)..... yrs. ..... mos. ..... ds.

(Signed) Edward Jones M. D.

Dec 23, 1922 (Address) 1 W. Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Morgans Cemetery Carroll Co Md

DATE OF BURIAL, Dec. 23, 1922

20-UNDERTAKER Margaret J. Flynn

ADDRESS 1422 Light St.

DEC 23 1922 Burial Permit Clerk.

B.—Every item of information should be carefully given. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70330 100-001 D70330

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 Somerset St ST. 10 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Powell Chase

(a) RESIDENCE NO. 521 Somerset St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 8, 1922

7 AGE — Years: — Months: 7 — Days: — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Raymond Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Emma Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Emma Chase
(Address) 521 Somerset St.

15 Filed ..... 19 .....
Robert P. Garrison.
Registrar
Burial Permit Clerk.

C 23 1922

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 21 1922

17

I HEREBY CERTIFY, That I attended deceased from December 18, 1922, to December 21, 1922, that I last saw her alive on December 20, 1922, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. L. W. Kennard M. D.

12-21 1922 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: Dec. 23 1922

20 UNDERTAKER: Mrs J. G. Locke

ADDRESS: 202 Jefferson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"): *Diphtheria* (avoid use of "Croup"): *Typhoid fever* (never report "Typhoid pneumonia"): *Lobar pneumonia: Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Don't Answer
If Primary

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70331

D70331

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME George Schroeder

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	89	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Municipal Hospital Records.

15 Filed ..... 19 ..... Registrar

DEC 23 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 21 1922

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to December 21, 1922.

that I last saw him alive on December 20, 1922.

and that death occurred, on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Autopsy

(Signed) Clyde Wilkins, M. D.

19 (Address) Dec. 21 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Dec. 25 1922

20 UNDERTAKER: Mr. & Mrs. John H. Leufelder Son — ADDRESS: 2 & 4 Fayette

N. B.—WRITE PLAINLY, with ink. All questions must be answered. AGE should be carefully supplied. Exact statement of each item should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70332

D70332

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4403 Maine Ave. ST.: 28 WARD)

2-FULL NAME Louise Krieb

(a) RESIDENCE. No. 4403 Maine Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew J. Krieb

6 DATE OF BIRTH (month, day, and year) July 11 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	51	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Kratz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret L. Kaplan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Andrew J. Krieb (Address 4403 Maine Ave

15 Filed DEC 23 1922 Robert P. Harrison, Registrar

DEC 23 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 20th 1922, to Dec 21st 1922.

that I last saw her alive on Dec 21st 1922.

and that death occurred, on the date stated above, at 1.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? c.

Did an operation precede death? No Date of c

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Microscopical

(Signed) August Hoen, M. D.

1922 (Address) 40 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Dec 23 1922

20 UNDERTAKER: M. & Mrs John W. Leufel & Son

ADDRESS: 801 W. Fayette

Should be carefully supplied. AGE should be properly classified. Exact statement of ... may be properly classified, so that it may ... CAUSE OF DEATH in plain terms, so that it ... back of certificates. ... TION is very important. See instructions on ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70333

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70333

CERTIFICATE OF DEATH.

REGISTERED NO. 18129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1146 W. Lombard St ST.: 18 WARD)

2-FULL NAME. Julia Ann McQuinn.

(a) RESIDENCE. NO. 1146 W. Lombard ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 5-1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	83	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) off

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs C. S. McQuinn
(Address) 1146 W. Lombard St

15 Filed ..... 19 ..... Registrar Robert P. Harrison,
Burial Permit Clerk.

C 231922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12.20.22 19

17 I HEREBY CERTIFY, That I attended deceased from 12.19.22, 19..., to 12.20.22, 19 ...,
that I last saw h.. alive on 12.20.22, 19 ...,
and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Philip S. Fowler, M. D.

12.23.22 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Dec 23 19 22

20 UNDERTAKER H. J. Waldo

ADDRESS 120 W Lombard

Information should be carefully supplied. AGE should be exact. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D70334

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70334

CERTIFICATE OF DEATH.

188-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Knight Jr

(Residence in Baltimore: No. Colgate St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Aug (Month) 5th (Day) 1878 (Year)

7-AGE: 44 yrs. 4 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE (State or Country): Md

PARENTS.

10-NAME OF FATHER: James H. Knight Sr

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary C White

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lilly M. Dorsey

(Address) 33 B do 3rd OK

15- Robert P. Harrison,

Filed..... 192.... Registrar.

Asst. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 21st (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Presumably struck by R.R. Engine

(Duration) yrs. mos. ds.

(Signed) Thos. B. Hodgen M. D. (Coroner.)

Dec 27 192 2 (Address) Curtis Bay

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means of Injury; and whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Cem	Dec 24, 1922

20-UNDERTAKER.	ADDRESS
Zirkles + Zirkles	1737 E Eager

N. B.—Every item of information should be carefully supplied. Exact statement of occupation may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

D70335

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70335

90

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Howard & Lexington ST.) 26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Eppler

(Residence in Baltimore: No. 3430 E Lombard

66 yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Married

6-DATE OF BIRTH, ... March (Month) ..... 1 (Day) ..... 1856 (Year)

7-AGE, 66 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)..... 806

9-BIRTHPLACE, (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Charles

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah E. Eppler

(Address) 3430 E. Lombard

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec. 20, ... 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by inquest, (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pyaemia, Tear Abscess,

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Dec. 22, 1922 (Address) 3332 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Howard & Lexington Sts

Former or usual residence 3430 E. Lombard St

19-PLACE OF BURIAL OR REMOVAL, Oaklawn

DATE OF BURIAL, 12/24/, 1922

20-UNDERTAKER William Cook

ADDRESS 507 E. North

N.B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

12 1922

Spec.—8-24-14—M. & T.—2000 Blks.

Jan 1919 20 Park St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70336

CERTIFICATE OF DEATH.

100-001 D70336

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4747 Park Heights Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Bernard Diederich

(Residence in Baltimore: No. 4747 Park Heights Ave St.; 51 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 2 (Day), 1871 (Year)

7-AGE, ...yrs. 6 mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm. L. Diederich

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Mary Spiegel

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. L. Diederich

(Address) 4747 Park Heights Ave

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

RC 231922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 22, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 30 1922, to Dec. 22 1922, that I saw him alive on Dec. 22 1922, and that death occurred, on the date stated above, at 5 30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Catherine Jaslin M. D.

Dec. 22, 1922. (Address) 1917 St. Paul

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, SC Pander

DATE OF BURIAL, Dec. 24, 1922

20-UNDERTAKER Wm Cook

ADDRESS 502 E. Lanvale

R.S.—Every item of information must be given in plain terms, so that it may be properly classified. Date of death, CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70337

D70337

100-001

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE: (No. No ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Godin

(a) RESIDENCE NO. Infirmary ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
71.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer) 084

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Infirmary

11 BIRTHPLACE OF FATHER (city or town) (State or country) do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) do

14 Informant Bayview Hospital (Address) Balto Md.

15 Filed 12/24/22 19 Registrar Robert P. Harrison,

Burial Permit Clerk

c/o American Express - Van Ness

N.B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70338

D70338

CERTIFICATE OF DEATH.

159-002

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1224 S Decker Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Cholewinski

(a) RESIDENCE. NO. 1224 S Decker Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 12-22

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Michal Cholewinski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Stefan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa

14 Informant Michal Cholewinski
(Address) 1224 S Decker Ave

15 Filed Robert P. Harrison Registrar

DEC 23 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-22 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922, to Dec. 21, 1922, that I last saw him alive on Dec. 21, 1922, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 8 days.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronnshan M. D.

12-22-1922 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Dec 23 1922
20 UNDERTAKER	ADDRESS
Stephen J Kraskowski	1005 Fleming St

INFORMATION should be carefully supplied. AGE should be correctly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70839 D70339

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1628 Pierce St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H. Henry

(a) RESIDENCE. No. 1628 Pierce St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Henry.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER Jacob Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant Annie Stanley

(Address) 628 Pierce St

15 Filed DEC 23 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1922 to Dec 21, 1922

that I last saw him alive on Dec 19, 1922

and that death occurred, on the date stated above, at 4.45 PM

The CAUSE OF DEATH* was as follows:

Myocarditis (duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Regular

What test confirmed diagnosis?

(Signed) H. E. Lunke, M. D.

, 19 (Address) 1313 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. DATE OF BURIAL 12/23 1922

20 UNDERTAKER Wm H. Stanley ADDRESS 628 Pierce St

N. B.—Information should be carefully supplied. Age should be accurately classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70340

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

119 D70340

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) ST., 17 WARD)

2-FULL NAME Columbus Gilmore

(a) RESIDENCE NO. 418 N. Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Ethel Gilmore

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 44 yrs; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norfolk, Va.

PARENTS

10 NAME OF FATHER: Chas Gilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.C.

14 Informant: Mr Gilmore (Address) 711 Georgia St

15 Filed DEC 23 1922 Robert F. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-17- 1922, to 12-21 1922,

that I last saw h~~im~~live on 12-21- 1922,

and that death occurred, on the date stated above, at 3pm m.

The CAUSE OF DEATH* was as follows:

Perirectal Abscess -

Infection & Necrosis

Cellulitis of Inguinal Regions -

2 weeks - (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Septicaemia

Cardiac failure - (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12-18-22

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Autopsy

(Signed) W. C. Caldwell M. D.

, 19 (Address) St Agnes Hosp -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL 12/23/22 19

20 UNDERTAKER: James L Kennedy

ADDRESS Md

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70341 D70341

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 Reservoir ST., 13 WARD)

2-FULL NAME Alfred E. Mealy

(a) RESIDENCE NO. 725 Reservoir ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie K. Mealy

6 DATE OF BIRTH (month, day, and year) July 16 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Druggist

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

025

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER James B. Mealy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah J. Clarke

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Maggie K. Mealy (Address) 725 Reservoir St.

15 Filed , 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

N. B.—WHITE PAPER. Information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/22 1922

17

I HEREBY CERTIFY, That I attended deceased from April, 1922 to 12/21, 1922, that I last saw h in alive on 12/21, 1922, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chronic intestinal nephritis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Hypertrophy of Myocardium pericarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical Tests

(Signed) Clarence Hebard, M. D.

12/23 1922 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Dec 24 1922

20 UNDERTAKER John O'Neill

ADDRESS 1201 N. Fayette

Spmc. 6-9-19—H. P. Co.—1000 Bks.

D70342 HEALTH DEPARTMENT—CITY OF BALTIMORE D70342

CERTIFICATE OF DEATH. 44

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Muniversity Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME See T. Eckels

(a) RESIDENCE. No. Westminister, Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rev. Merrin J. Eckels

6 DATE OF BIRTH (month, day, and year) 1855 Aug

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER James B. Kenly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Phoebe Cook.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Mae L. Hopper 624 Braunt Ave

15 Filed DEC 24 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22, 1922.

17 I HEREBY CERTIFY, That I attended deceased from 12/15, 1922, to 12/22, 1922, that I last saw h-er alive on 12/22, 1922, and that death occurred, on the date stated above, at 3.01 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of gall bladder

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/21/22.

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) J. Willis Gaynor M. D.

, 19 (Address) Muniversity Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockburn Harford Co. DATE OF BURIAL Dec. 24 1922

20 UNDERTAKER John O. Mitchell ADDRESS 120 W. Fayette

mation should be carefully supplied. And should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

D70343

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70343

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 S Robinson ST., 1 WARD)

2-FULL NAME Emma J. Hendricks

(a) RESIDENCE NO. 204 S. Robinson ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Winfield S Hendricks

6 DATE OF BIRTH (month, day, and year) Feb 19 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Washington Co (State or country) Maryland

PARENTS

10 NAME OF FATHER Moses Lichty

11 BIRTHPLACE OF FATHER (city or town) York Co (State or country) Pa

12 MAIDEN NAME OF MOTHER Maria Smith

13 BIRTHPLACE OF MOTHER (city or town) Washington Co (State or country) Maryland

14 Informant Mrs Benj B. Harrison
(Address) 204 S Robinson

15 Filed ... 19... Robert P. Barrison Registrar

DEC 23 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1-1922 to Dec. 21 1922, that I last saw h[illegible] alive on Dec 21 1922, and that death occurred, on the date stated above, at 5.35 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(duration) ... yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) H. Herrmann, M. D.

12/23, 19 22 (Address) 1914 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Dec 24 1922

20 UNDERTAKER John H Deeny — ADDRESS 715 Light St

N. B. Information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70344

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70344

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1224 (Street) Aisquith (Ward) 10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca C. Wilcox

(a) RESIDENCE NO. 1224 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 2 mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: the late John F. Wilcox

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE: Years 85 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Md.

PARENTS

10 NAME OF FATHER: William A. Stonner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md.

12 MAIDEN NAME OF MOTHER: Sarah Prime

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Md.

14 Informant: Mrs Mary Shawen

(Address) 1224 Aisquith St

15 Filed 19 Robert F. Harrison, Registrar

C 23 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 22 1922

17

I HEREBY CERTIFY, That I attended deceased from June 21, 1920, to Dec 22, 1922, that I last saw h alive on Dec 21, 1922, and that death occurred, on the date stated above, at 11 45 A.M.

The CAUSE OF DEATH* was as follows:

Cardio-vascular disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert Carey, M. D.

Dec 22 1922 1716 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Dec. 26 1922

20 UNDERTAKER: Henry Woeckner Son — ADDRESS: 1301 E. Eager St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70345 HEALTH DEPARTMENT—CITY OF BALTIMORE D70345

CERTIFICATE OF DEATH. 74-004 Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 805 So. Potomac St., 1 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Lautner
(Residence in Baltimore: No. 805 So. Potomac St.; 34 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Feb (Month) 1st (Day) 1888 (Year)

7-AGE. 62 yrs. 11 mos. 22 ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country). Austria

PARENTS.
10-NAME OF FATHER, Joseph Schneider
11-BIRTHPLACE OF FATHER, (State or Country) Austria
12-MAIDEN NAME OF MOTHER, Magdalena Finn
13-BIRTHPLACE OF MOTHER, (State or Country) Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frederick H. Schneider
(Address) #2 E. Redwood

15- Filed ..... 192..... Robert P. Harrison, Registrar.

DC 231922 Burial Permit Clerk

N.B.—Every item of information should be carefully supplied. Exact statement of cause may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificate. is very important.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 22nd (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy
Varicel
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.
Coroner.
Dec 27 1922. (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Burns, Ped.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cremation Loudon Park Cemetery	Dec 23, 1922
20-UNDERTAKER.	ADDRESS
H. Sander & Sons	1710 Eutaw St

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Travis)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70346

CERTIFICATE OF DEATH.

101-001

D70346

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 N. Dallas ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stella Travis

(a) RESIDENCE. No. 815 N. Dallas ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 COLOR OR RACE: Colord

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1876

7 AGE 46 Years — Months — Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Charles Gramby

11 BIRTHPLACE OF FATHER (city or town) (State or country) n c

12 MAIDEN NAME OF MOTHER Mary grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) n d

14 Informant Addie Smith (Address) 815 n dallas st

15 Filed 19[illegible] Robert P. Carrison Registrar

DEC 23 1922 [illegible] Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug, 1922, to Dec 21, 1922, that I last saw h[illegible] alive on Dec 21, 1922, and that death occurred, on the date stated above, at 8 A.M. The CAUSE OF DEATH* was as follows: (Pneumonia Lobar

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (a) Pneumonia (Secondary)

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Observation by Physician

(Signed) A. W. Finch M. D.

Dec 22 (Address) 712 S Dallas Apt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
mt auburn Cemetry	Dec 24 1922
20 UNDERTAKER	ADDRESS
John H Toadvine	142 Hill St

R. B.—WRITE PLAINLY. All questions should be answered. AGE should be stated. Information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D70347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70347

38

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 17 WARD)

2-FULL NAME Stanley Smith

(a) RESIDENCE No. 778 N. Bradley st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or min.
	20			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sailor
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mamie Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address) Robert P. McTeller

DEC 23 1922 Buried, Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21, 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1922, to Dec. 21, 1922, that I last saw him alive on Dec. 21, 1922, and that death occurred, on the date stated above, at 1.03 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 7 mos ..... ds.

CONTRIBUTORY (Secondary) Syphilis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frances L. Babcock M. D.

12-21, 1922 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 12-23 1922

20 UNDERTAKER Daniel Tarbox

ADDRESS 916 Pleasant

WRITE PLAINLY—All items should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70348

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70348

CERTIFICATE OF DEATH.

X 131

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

CITY OF BALTIMORE: (No. FT. MCHENRY, BALTIMORE, MD ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CHEW, Jonas C.

(a) RESIDENCE NO. 2347 Oliver St., Philadelphia, Pa. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	27	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) --
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) --
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) --
(State or country) Unknown

14 Informant Hospital Records
(Address) Fort Mc Henry, Baltimore, Md.

15 DEC 23 1922 . 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 22 19 22.

17

I HEREBY CERTIFY, That I attended deceased from January 20 , 19 22 , to December 22 , 1922. ,

that I last saw him alive on December 22 , 1922. ,

and that death occurred, on the date stated above, at 10:50 A. m.

The CAUSE OF DEATH* was as follows:

Uremia, acute

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Renal Insufficiency

- (duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical History.

(Signed) H. L. Lusk Surgeon (R), M. D.

, 19 (Address) Fort McHenry, Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa

DATE OF BURIAL 12/23 1922

20 UNDERTAKER S. Levinson & Bro

ADDRESS 1127 E Balto St

DEC 23 1922

N.B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in YEARS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70349

CERTIFICATE OF DEATH.

X 43 D70349

REGISTERED NO.

1-PLACE OF DEATH Howard A. Kelly Hospital

CITY OF BALTIMORE: (No. 1418 Eutaw Pl. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pliny B. McNaughton

(a) RESIDENCE. NO. Big Tree Road Lackawanna N.Y. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married (Francis)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Pliny B. McNaughton

6 DATE OF BIRTH (month, day, and year) Aug 17 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70+	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired from Contractor

(b) General nature of Industry, business, or establishment in which employed (or employer) Business 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Buffalo New York

PARENTS

10 NAME OF FATHER Daniel McNaughton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Campbelltown Scotland

12 MAIDEN NAME OF MOTHER Pamela Barton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Buffalo New York

14 Informant Mrs Frances McNaughton (Address) Buffalo New York

15 Filed Robert P. Harrison, Registrar

C 231922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1913, to Dec 23, 1922

that I last saw h.im alive on Dec 22, 1922

and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? At Home

Did an operation precede death? Yes Date of Dec. 9, '22

Was there an autopsy? No

What test confirmed diagnosis? Path. Exam.

(Signed) Grant E. Ward, M. D.

, 19 (Address) 1418 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Buffalo New York	Dec. 23 1922
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North Ave

N. B.—Name should be carefully supplied. Age should be carefully supplied. Exact statement of occupation should be properly classified. Exact statement of place of death in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death in plain terms, so that it may be properly classified. Exact statement of occupation should be properly classified. Exact statement of place of death in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70350 — 129 — D70350

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1600 Oakland St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W Smith

(a) RESIDENCE. NO. 1600 Oakland ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Ellen Nora Smith

6 DATE OF BIRTH (month, day, and year) Oct 13 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) — 86

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co -

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Richard Smith

(Address) 2 22 Eccleston Ave

15 Filed DEC 23 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23-1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1922, to Dec 23, 1922, that I last saw h— alive on Dec 22, 1922, and that death occurred, on the date stated above, at 2.20 A m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

Chronic Endocarditis

Nephritis

No Paralysis

CONTRIBUTORY (Secondary) (duration) 1 yrs. mos. ds.

No Operation

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Howard W Jones, M. D.

. 19 (Address) 222 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden

DATE OF BURIAL 12/26 192

20 UNDERTAKER William Coile

ADDRESS 502 E North Ave

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

15-8995 D70351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 100-001 D70351

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE. (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luther Stakes

(a) RESIDENCE NO. Edgewood Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 weeks mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stateman

(b) General nature of industry, business, or establishment in which employed (or employer) 924

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wilson Stakes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Angelia Badkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 JOHNS HOPKINS HOSPITAL.

Informant

(Address)

15 Filed ....., 19 .....

Robert P. Harrison, Registrar

DEC 23 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 - 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 10, 1922 to Dec 21, 1922,

that I last saw him alive on Dec 21, 1922

and that death occurred, on the date stated above, at 6.40 a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia left lower

Septicemia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Edgewood Md

Did an operation precede death? Yes Date of 12/14/22

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Warfield M. Firor, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL Dec 23 1922

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

N. B.—WRITE plainly. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Information is very important.

Spec.—1-10-21—M&T—1500 Bks.

D70352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70352

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 843 N. Lee St ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. McCarthy

(a) RESIDENCE NO. 843 N. Lee St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 13 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ref Hire clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John McCarthy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ellen Crosty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Geo Bell

(Address) 639 N Schroeder St

15 Filed ....., 19..... Robert P. Harrison Registrar

Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 192

17

I HEREBY CERTIFY, That I attended deceased from July 11, 1922, to Dec 1, 1922,

that I last saw h[illegible] alive on Dec 1, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Eden V Cochran, M. D.

12/23/1922 (Address) 211 N Hilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 12/26 1922

20 UNDERTAKER Henry C Brauning 1800 — ADDRESS 5171 Schroeder

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70353

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70353

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2247 Eutaw Place ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Sinsheimer

(a) RESIDENCE. NO. 2247 Eutaw Place ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or Divorced ~~(write the word)~~: widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: wife deceased

6 DATE OF BIRTH (month, day, and year): Jan 11 1829

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired flour

(b) General nature of industry, business, or establishment in which employed (or employer): merchant - 45 0

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Simon Sinsheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Hanth Hartfeg

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Sadie J. Sinsheimer

(Address) 2247 Eutaw Place

DEC 23 1922, 19

ROBERT F. BARTHOLOW, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 2d, 1922, to Dec 22d, 1922, that I last saw him alive on Dec 22, 1922, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cardiac dilation, Myocarditis, arteriosclerosis,

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Oedema, Exhaustion

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Joseph Eichner, M. D.

(Address) 1st & Madison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Har Sinai Cemetery

DATE OF BURIAL: Dec 24/ 1922

20 UNDERTAKER: J. Ahrens & Co.

ADDRESS: 1611 Hillsdale Ave

NOTE—WRITE PLAINLY, WITH LEAD PENCIL. All items must be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70354

CERTIFICATE OF DEATH.

151 D70354

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Brown

(a) RESIDENCE NO. 1022 Carleton St ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Brown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	11 LESS than 1 day, ... hrs or ..... min.
	52	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anna Arundal Co., Maryland

PARENTS

10 NAME OF FATHER Samuel Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anna Arundal Maryland

12 MAIDEN NAME OF MOTHER Mary James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anna Arundal Maryland

14 Informant Municipal Hospital Records. (Address)

15 ....., 19..... Registrar

C 23 1922

Robert P. Garrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21 19 22

17 I HEREBY CERTIFY, That I attended deceased from November 24, 19 22, to December 21, 19 22, that I last saw her alive on December 20, 19 22, and that death occurred, on the date stated above, at 8:10 A.M.

The CAUSE OF DEATH* was as follows:

Senile Gangrene of Left Foot with Secondary Infection

(duration) yrs. mos 7 wks.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) J. Richardson Joyner M. D.

12/21/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state the Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL Dec 24 1922

20 UNDERTAKER Samuel N. Chase & Son ADDRESS 1400 Mosher

Information should be carefully supplied. All items must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70355

CERTIFICATE OF DEATH.

9 D70355

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 S Clarke ST. 23 WARD)

2-FULL NAME Audrey M. Schneider

(a) RESIDENCE NO. 1622 S Clarke ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER George W. Schneider Jr

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Marie McCabe

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant George W. Schneider Jr
(Address) 1622 S Clarke St

15 Filed DEC 23 1922 19 Robert F. Harrison
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1922, to Dec 23, 1922, that I last saw her alive on Dec 23, 1922, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Whooping Cough &
Cholera Infantum

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. L. Campbell M. D.

Dec 23, 1922 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL Dec 24 19 22

20 UNDERTAKER E. Schloman's Son — ADDRESS 1039 Hanover St.

Burial Permit Clerk

N. B. [illegible] mation should be carefully supplied. AGE should be [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

070356 HEALTH DEPARTMENT—CITY OF BALTIMORE 070356

CERTIFICATE OF DEATH. 45

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Westwood Ave St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert May Simmons

(a) RESIDENCE. NO. 1704 Westwood Ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hubert B. Simmons

6 DATE OF BIRTH (month, day, and year) May 9th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newport Kentucky

PARENTS

10 NAME OF FATHER James Hays

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Hahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Mrs Blanche Oconnor 1704 Westwood Ave

15 Filed , 19 Robert T. Harrison, Registrar

C 231922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th 1922, to Dec 22, 1922, that I last saw h alive on Dec 20th, 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of small intestine.

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Palpation.

(Signed) A. C. Simmons M. D.

(Address) 4309 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL Dec 23" 22 19

20 UNDERTAKER Joseph B. Cook ADDRESS 1a 3 W. Balto St

mation should be carefully supplied. Any answer not known to be properly classified. Exact statement of occupa... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70357

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70357

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 Mary Lunger ST., 20 WARD)

2-FULL NAME Baby Thompson

(a) RESIDENCE NO. 316 N. Installroad ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wht.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 20-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Alton Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Bertha Krapf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Alton Thompson (Address) 316 Installroad St.

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk

C 231922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 22 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-20, 1922, to 12 22, 1922, that I last saw him alive on 12-22, 1922, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Stuart Carr, M. D.

12 23 1922 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Dec 23 1922

20 UNDERTAKER: George L. Schwab — ADDRESS: 501 Fulton Ave

N.B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in every case. Exact statement of DISEASE or CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks. No. 0290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70358 D70358

CERTIFICATE OF DEATH.

REGISTERED NO. 41

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1406 McElderry ST.: 5 WARD)

2-FULL NAME Louisa Keys

(a) RESIDENCE. No. 1406 McElderry ST WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Col | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Noble Keys

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER Thomas Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Noble Keys 1406 McElderry St

15 Filed ..... 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk.

DEC 2 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1922, to Dec 20, 1922, that I last saw h a alive on Dec 20, 1922, and that death occurred, on the date stated above, at 5 40 P m.

The CAUSE OF DEATH* was as follows:

Uremic Ephcaumia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles W Whitehead M. D.

12/22, 1922 (Address) 1810 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: Dec 24 1922

20 UNDERTAKER: John W Henderson — ADDRESS: 1503 Eutaw

P. S.—Write plainly. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Due to Bad Teeth

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70359

D70359

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST. 10 WARD)

2-FULL NAME Laura Miller

(a) RESIDENCE NO. 878 St. John's Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Joseph Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Laura Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records M.T.H.

15 DEC 23 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 21, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1922, to Dec. 21, 1922, that I last saw her alive on Dec. 21, 1922, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? B. T. in sputum, X-ray

(Signed) Francis Dalaglacco M. D.

12-21 19 22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Dec. 23 1922

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS 1735 Ashland Ave

B. Exact statement of DISEASE should be carefully supplied. AGE should be properly classified. Information in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

70360 D70360

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 70360 D70360

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1420 Hempel Alley, 12 WARD)

2-FULL NAME Henry Wilson Berry

(a) RESIDENCE NO. 1420 Hempel Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Lewis E. Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Gladys Nicholson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant R. J. Young (Address) 1429 E. Monument St

15 DEC 24 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922, to Dec 22, 1922, that I last saw him alive on Dec 21, 1922, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

, 19 (Address) 1429 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: 12/27/22 19

20 UNDERTAKER: George J. Roth ADDRESS: 1735 Hayward Ave

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

70361
D70361

HEALTH DEPARTMENT—CITY OF BALTIMORE

70361
D70361

CERTIFICATE OF DEATH.

113

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2446- Montebello Ave 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Clarence E. Taylor

(Residence in Baltimore: No. 2446- Montebello Av St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M.	W	S

6-DATE OF BIRTH. June (Month) 2 (Day) 1922 (Year)

7-AGE. ....yrs. 6 mos. 20 ds. If LESS than 1 day ....hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Clarence E Taylor

11-BIRTHPLACE OF FATHER. (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Edna Muth

13-BIRTHPLACE OF MOTHER. (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Muth.

(Address) 2446-Montebello Av

15. Filed DEC 24 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 23 (Day) 192.7 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions -
Probably Gastro-Intestinal
Indigestion
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....
(Duration) 2 yrs. mos. ds.

(Signed) J. S. H. Culler M. D.
(Coroner.)

12-23 192.7 (Address) 1.1.8 E Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs. 1 mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt. Olivet Cem. DATE OF BURIAL. 12/25/22 19....

20-UNDERTAKER. Geo. J. Ruth ADDRESS 1735 Harford Ave

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement is required. In state CAUSE OF DEATH in plain terms

Spec.—1-10-21—M&T—1500 Bks.

16262 70362 D70362

HEALTH DEPARTMENT—CITY OF BALTIMORE

70362 X 48 D70362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah June Rounds

(a) RESIDENCE NO. 1632 S. NW. Washington D.C. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5n If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 4-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia (State or country) Penn

PARENTS

10 NAME OF FATHER Franklin Colhoun

11 BIRTHPLACE OF FATHER (city or town) Philadelphia (State or country) Penn

12 MAIDEN NAME OF MOTHER Susanna O'Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed DEC 24 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 12 —, 1922, to Dec 23 1922.

that I last saw her alive on Dec. 23rd, 1922

and that death occurred, on the date stated above, at 8 25 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the nasopharynx
Secondary anemia

(duration) 1 yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) Carcinoma of blood vessel

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde A. Heathy, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa. DATE OF BURIAL 12/25/22

20 UNDERTAKER H E Stughes ADDRESS 1st St. Broadway

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be exact. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

D 70363

HEALTH DEPARTMENT—CITY OF BALTIMORE D70363

CERTIFICATE OF DEATH.

1179 V

10363

Registered No. D 70363

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Rose Di Fatta (Di Fatta)

(Residence in Baltimore: No. 521 Colvin st. St.; yrs. mos. ds.)

N. B.—Every item of information should be given, and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Sept. (Month) 20 (Day) 1870 (Year)

7-AGE: 52 yrs. 3 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): — 087

9-BIRTHPLACE, (State or Country): Italy.

PARENTS.

10-NAME OF FATHER: Sam. Brocato

11-BIRTHPLACE OF FATHER, (State or Country): Italy.

12-MAIDEN NAME OF MOTHER: Anna Brocato

13-BIRTHPLACE OF MOTHER, (State or Country): Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicola Di Fatta.

(Address) 521 Colvin st

15- DEC 24 1922 Filed 192 ROBERT H. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 23-22 (Day) (Year) 192

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns - general

Accidental - Burns caught fire from stove

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dickey M. D. (Coroner)

Dec 24 1922 (Address) 16 39 Bucodry

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Vincent Cem	Dec 24th 19 22

20-UNDERTAKER.	ADDRESS
Geo. J. Ruth	1735 Harford ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

70364

D70364

CERTIFICATE OF DEATH.

X 31

D70364

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1828 W. Franklin ST., 20 WARD)

2-FULL NAME George McC. Beck

(a) RESIDENCE NO. 1828 W. Franklin ST., WARD 20th

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowered

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Florence V. Beck

6 DATE OF BIRTH (month, day, and year) Aug 8, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	58 4m	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Repairer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mc Knight Pa

PARENTS

10 NAME OF FATHER George J. Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Mrs Clare E. KRIXER

(Address) 1828 W. Franklin st

15 Filed DEC 24 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1922, to Dec 23rd, 1922, that I last saw him alive on Dec 23rd, 1922, and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Fibroid TB (pulmonary)

(duration) 15 yrs mos ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. R. Krexer M. D.

12/23 1922 (Address) 614 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gettysburg Pa — DATE OF BURIAL Dec 25 1922

20 UNDERTAKER Jos Joerdens Son — ADDRESS 2178 Penn

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be given. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D70365 70365 1922 38

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70365 1884

CERTIFICATE OF DEATH.

REGISTERED No. C.....

(If death occurred in a hospital or institution, give, its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1031 N Stockton St.: 16 WARD)

2-FULL NAME Rosie Freshor

(Residence in Baltimore: No. 1031 N Stockton St.: yrs. 67 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 5, 1884 (Month) (Day) (Year)

7-AGE 38 yrs. 11 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work, Domestic (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). City

PARENTS.

10-NAME OF FATHER John Wright

11-BIRTHPLACE OF FATHER (State or Country) Md. U. S.

12-MAIDEN NAME OF MOTHER Rebecca Brown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Liza Mackums

(Address) 1031 N Stockton

15- Filed DEC 24 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 23, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Dec. 24, 1922 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Dec 24, 1922

20-UNDERTAKER Frances E Leigh

ADDRESS 1564 Mary

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

70366

CERTIFICATE OF DEATH.

60-001

D70366

D70366

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Division ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Butler

(a) RESIDENCE. NO. 1617 Division ST., 14 WARD.

(Usual place of abode) (If nonresident give city or town and State)

, Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel T Butler

6 DATE OF BIRTH (month, day, and year): Sept 21, 1870

7 AGE: Years 52 yrs; Months 1870 Sept; Days 21

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Highland Howard Co Maryland

PARENTS

10 NAME OF FATHER: Samuel T. Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Matilda Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co Maryland

14 Informant: Samuel T Butler

(Address): 1617 Division St

15 Filed DEC 24 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec-1- 1922, to Dec 22, 1922

that I last saw h alive on Dec 22, 1922

and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH was as follows:

Goitre Exophthalmic

(duration) not clear yrs. mos. ds.

acute Cardiac Dilatation (Goitre heart)

CONTRIBUTORY (Secondary) (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? clinical

(Signed) S P Stughes M. D.

Dec 23, 1922 (Address) 1413 E. Fillmore Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Keyser

DATE OF BURIAL: 12/24/19

20 UNDERTAKER: Samuel Kennedy

ADDRESS: Md

mation should be carefully supplied. ... that it may be properly classified. Exact statement of ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bk. 70367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70367

REGISTERED NO. D70367

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 Argyle Ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Moore

(a) RESIDENCE NO. 1410 Argyle Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1903

7 AGE Years 19 Months Days

If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Md Baltimore

PARENTS

10 NAME OF FATHER Samuel Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma D. Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Moore (Address) 1410 Argyle Ave

15 Filed DEC 24 1922 By ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 22 1922

17 I HEREBY CERTIFY, That I attended deceased from October 24, 1922, to December 22, 1922, that I last saw her alive on December 21, 1922, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

Tuberculosis (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. J. W. Kennard, M. D.

12-24-22 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

UNDERTAKER Samuel J. Kennedy

DATE OF BURIAL 12/24/1922

ADDRESS 1775 McCulloh

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70368

D70368

REGISTERED NO. 91-002

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1029 N Fallso. ST., 7 WARD)

2-FULL NAME Maria Buddenbohn.

(a) RESIDENCE NO. 1029 N Fallso ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Buddenbohn July 1839.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Fred Wittemyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Frederick Buddenbohn (Address) 1029 N Fallso St.

15 Filed DEC 24 1922 ROBERT R. KRAUER, Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 22 1922 to Dec 22 1922

that I last saw her alive on Dec 22 1922

and that death occurred, on the date stated above, at 10½ P m.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Decay

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Syracuse

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theo Thies, M. D.

Dec 24, 1922 (Address) 1501 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emanuel Cemetery DATE OF BURIAL Dec 27 1922.

20 UNDERTAKER A. Freeman. ADDRESS 320 Fulton Ave.

N. B. All information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. MEDICAL CERTIFICATION is very important.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70369

REGISTERED NO. 91-00 D70369

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 762 W St Paul ST., 12 WARD)

2-FULL NAME Richard Bryson Price

(a) RESIDENCE NO. 762 W St Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Price

6 DATE OF BIRTH (month, day, and year) March 19-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self 845

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ann Bryson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address)

15 DEC 24 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1922, to Dec 22, 1922

that I last saw h[illegible] alive on Dec 22, 1922

and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebro Sclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White Jr, M. D.

, 19 (Address) 2800 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Dec 24 1922

20 UNDERTAKER Wm. J. Friedrichs Sons

ADDRESS Baltimore

N. B. [illegible] should be carefully supplied. AGE should be properly classified. Exact statement of DECEASED'S OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

D70370 ✓ 70370

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70370 90

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 N Monroe Street ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

2-FULL NAME Morris Hillelman (If under 1 year, ... yrs., ... mos. ..... ds.)

(Residence in Baltimore: No. 1709 N Monroe Street St.; 15

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1863 (Year)

7-AGE. 59 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Schocher (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Fishel Hillelman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Lea Keler

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Baltimore St

15-DEC 24 1922 Filed ....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 23 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 17 1922 to Dec 23 1922, that I saw h.. alive on Dec 23 1922, and that death occurred, on the date stated above, at 10 A.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus 20 ds.

(Duration) ..... yrs. ..... mos.

CONTRIBUTORY (Secondary) Myocardial Insufficiency 1 ds.

(Duration) ..... yrs. ..... mos.

(Signed) M. K. Hillelman M. D.

Dec 23 1922 (Address) 1570 N Bentalou St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mehren Russedale

DATE OF BURIAL, 12/24, 1922

20-UNDERTAKER Jack Lewis

ADDRESS 1439 E Balt St

N. B. Entries must be made in INK and CAUSE OF DEATH in plain terms, so that it may be properly classified. All items are important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

70371

CERTIFICATE OF DEATH. 74-001

D70371

REGISTERED NO. D70371

1-PLACE OF DEATH D70371

CITY OF BALTIMORE: (NO. 131 Birckhead St. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma M. Dougherty

(a) RESIDENCE NO. 131 Birckhead St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married c

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Dougherty

6 DATE OF BIRTH (month, day, and year) Apr. 6 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	68	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Casper Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Frank Martell 131 Birckhead St.

15 Filed DEC 24 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 19 22

17 I HEREBY CERTIFY, That I attended deceased from 12/ 2 , 19 21 , to Dec 22 , 19 22 , that I last saw h alive on Dec 22 , 19 22 , and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mitchell M. D.

12/22 19 22 (Address) 1279 Pulaski St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 12/24 19

20 UNDERTAKER L. Fiss McCully

ADDRESS 130 E. Fort

mation should be carefully supplied. Exact statement of occupa
it may be properly classified. Exact statement of occupa
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70372 — 90 — D70372

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. W. Grpth Ave ST., 7 WARD)

2-FULL NAME John Roberson.

(a) RESIDENCE No. 913 N. Patterson Pk Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 9 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Minnie Roberson

6 DATE OF BIRTH (month, day, and year) May 15-45

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
77.	—	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Roberson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Henry W. Roberson 913 N. Pat Pk Ave

15 Filed DEC 24 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 22 to Dec 23, 1922

that I last saw him alive on Dec 23, 1922

and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocard Insuff.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What tests confirmed diagnosis? —

(Signed) Gabheuouch jr., M. D.

(Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL 12/26 1922

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70373 ✓ 70373

D70373 1-PLACE OF DEATH

CERTIFICATE OF DEATH. 188-003

Registered No. D70373

City of BALTIMORE: (No. Johns Hopkins Hosp St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry G. Green

(Residence in Baltimore: No. 1402 1st St. (Country) St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Aug (Month) 28 (Day) 1878 (Year)

7-AGE. 44 yrs. 4 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 531

9-BIRTHPLACE. (State or Country) Balto, Md.

PARENTS.

10-NAME OF FATHER. Charles W. Green

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Rebecca E. Lynch

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hosp

(Address) Person

15-Filed DEC 24 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 22 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure - Fracture of 7th Dorsal Vertebra - compression of cord. Automobile accident

Nov 19/22 (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) J. S. Falk M. D. (Coroner.)

12-23 1922 (Address) 508 E. Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Carmel	Dec 26, 1922
20-UNDERTAKER. Zirkler & Zirkler	ADDRESS 139 Eager

I. S. Copy of CAUSE OF DEATH in plain terms, so that it may be published, is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

160182 # D70374

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112 ✓ 10374 X D70374

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST., 7 WARD)

2-FULL NAME Dr. George A. Wilson

(a) RESIDENCE No. 33 W. 42nd St. New York City ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 24 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of J. P. Garet, Brother-in-law

6 DATE OF BIRTH (month, day, and year) July 9, 1873.

7 AGE: Years 49 | Months 5 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): (same)

(c) Name of employer: (same)

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George A. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Laura T. Merrill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Johns Hopkins Hosp. Records
(Address)

15 Filed DEC 24 1922 ROBERT H. KNAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1922, to Dec. 24, 1922.

that I last saw him alive on Dec. 24, 1922, and that death occurred, on the date stated above, at 5:40 A.M.

The CAUSE OF DEATH* was as follows:

Peritonitis following gastro-enterostomy

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of: Dec-11-1922

Was there an autopsy? Yes

What test confirmed diagnosis? ...

(Signed) Myron E. Goodheart, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Md.

DATE OF BURIAL: 12/26 1922

20 UNDERTAKER: J. Ahrens & Bro. 221

ADDRESS: Broadway

mation should be carefully supplied. ... Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D70375

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70375

161-001 70375

CERTIFICATE OF DEATH.

Registered No. D70375

1-PLACE OF DEATH

City of BALTIMORE: (No. 2631 Borne St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Sims

(Residence in Baltimore: No. 2631 Borne St St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH. Dec 21 1922
(Month) (Day) (Year)

7-AGE. ....yrs.....mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. —
(b) General nature of Industry, business, or establishment in which employed (or employer). 00

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. George Sims

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Laura Brown

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Sims (Father)

(Address) 2631 Borne St

15- DEC 24 1922 192.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23 192.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) 7 months gestation

(Duration).....yrs.....mos.....ds.

(Signed) J. Sholter (Coroner) M. D.

12-23 1922 (Address) 508 E Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cem.	Dec 25 1922
20-UNDERTAKER. Mrs J. G. Locks	ADDRESS 1812 Jefferson

R. S. [illegible] may be properly classified. Entire information should be given, and the cause of death must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Entire information should be given, and the cause of death must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Entire information should be given, and the cause of death must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Entire information should be given, and the cause of death must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Entire information should be given, and the cause of death must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Entire information should be given, and the cause of death must state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70376 D-70376

D70376

CERTIFICATE OF DEATH 71-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST.; 4 WARD)

2-FULL NAME Harriett Ann Bell

(a) RESIDENCE. NO. Highland Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) — 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records.

(Address)

15 Filed DEC 24 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/23 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/21, 1922, to 12/23, 1922, that I last saw her alive on 12/23, 1922, and that death occurred, on the date stated above, at 8 15 A. m.

The CAUSE OF DEATH* was as follows:

Pneumococcic Meningitis

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Highland Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Milton C. Levy, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hopkins Chapel Cem DATE OF BURIAL Dec. 26 1922

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

70377 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 70377

D70377 CERTIFICATE OF DEATH. REGISTERED NO. D70377

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert W. Newberry.

(a) RESIDENCE No. 1819 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colrd	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov 23 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24 yrs	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) automobile

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John T. Newberry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Nancy G. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant E. P. Summerfield

(Address) 2420 Eutaw Ave

15 Filed DEC 25 1922 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23rd 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 22, 1922, to Dec 23, 1922, that I last saw h[illegible] live on Dec 22nd, 1922, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Pneumococcus Type I)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not able to say

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological Study

(Signed) Chas. W. Cushing M.D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va

DATE OF BURIAL 12/25 19 22

20 UNDERTAKER Chas F. Evans & Son

ADDRESS 1111 Royal Ave

mation should be carefully supplied. Note also that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

70378 D70378

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

70378 D70378

161-001

1 PLACE OF DEATH — Registered No. C

CITY OF BALTIMORE (No. 1227 E. Fayette St. St. 46 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Anna Forsythe

(Residence in Baltimore: No. 1227 E. 76th St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: 12/22/22, 1 (Month) (Day) (Year)

7 AGE: yrs. mos. 1 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Harry Forsythe

11 BIRTHPLACE OF FATHER (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Anna Jangman

13 BIRTHPLACE OF MOTHER (State or country): Balto; Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Forsythe
(Address) 1427 S. 7th St

15 Filed DEC 25 1922, 191 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 12 (Month) — 22 (Day), 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 12/22/22, 191 , to 12/22/22 191
that I saw h[illegible] alive on 12/22/22, 191
and that death occurred, on the date stated above, at m
The CAUSE OF DEATH* was as follows:

Premature product of conception

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) G. J. Francis M. D.
12/24, 191 2 (Address) 2439 W. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Dec 25, 1922

20 UNDERTAKER: J Deeley — ADDRESS: 2005 Aliceanna

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks

70379 D70379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

70379 129 D70379

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 S. East Ave ST. 116 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Calvin Gilbert

(a) RESIDENCE NO. 231 S. East Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah F. Gilbert

6 DATE OF BIRTH (month, day, and year) Jan 17-1850

7 AGE: Years 72 Months 11 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co (State or country) Md

PARENTS

10 NAME OF FATHER Geo Gilbert

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Dora Evans

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs Estelle Frances (Address) 231 S East Ave

15 Filed DEC 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20, 19 18, to Dec 23, 19 22.

that I last saw h[illegible] alive on Dec 23, 19 22.

and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Paranephromalum Nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) [illegible], M. D.

12-26 1922 (Address) 330 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cooptown Harford Co Md

DATE OF BURIAL Dec 26 1922

20 UNDERTAKER John Ellerich

ADDRESS 2006 Aliceanna

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be given. Exact statement of occupation is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

160053 HEALTH DEPARTMENT—CITY OF BALTIMORE

D70380 CERTIFICATE OF DEATH. 159-003 D70380

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rafael Barnona

(a) RESIDENCE NO. 725 E. Chase St. City. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~or) WIFE of~~ Lewist Anna Barbona.

6 DATE OF BIRTH (month, day, and year) Nov. 28th 1922.

7 AGE: Years — Months — Days 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER Lewis, Barnona

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Iguillante

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) JOHNS HOPKINS HOSPITAL Records

15 DEC 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922 to Dec. 18 1922.

that I last saw ~~he~~ alive on Dec 18 1922.

and that death occurred, on the date stated above, at 9¼ P. m.

The CAUSE OF DEATH* was as follows:

Multiple congenital malformations (hands, feet, mouth, jaw, heart).

(duration) Life yrs. mos ds.

CONTRIBUTORY (Secondary) Asphyxia (See other side) terminal

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. A. Meech M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health

DEC 2 1922

mation should be carefully supplied. AGE should be entered in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

4463

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70381

D70381

CERTIFICATE OF DEATH.

44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 E Balto St ST.; 6 WARD)

2-FULL NAME Tillie Lahn

(a) RESIDENCE. No. 2100 E. Balto ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant A. Lahn

(Address) 1232 E Fairmount ave

Filed DEC 25 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1922, to Dec. 22, 1922, that I last saw her alive on Dec. 22, 1922, and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Mayo Boyle, M. D.

12/24, 1922 (Address) 210 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	Dec 25 1922
20 UNDERTAKER	ADDRESS 1127
Mat Leinwand	E Balto St

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D70382

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70382

188-003

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hebrew Hospital ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Shapiro

(Residence in Baltimore: No. 910 Aisquith Street St.; yrs. 16 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F	White	Widow

6-DATE OF BIRTH, October ....., 1 .....
(Month) (Day) (Year)

7-AGE, 78 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... G.D.

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E. Baltimore St.

15- DEC 25 1922 ROBERT R. KRAUTER
Filed....., 191.... Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 — 24 ....., 19 22
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Compound Fracture of Lt Femur Tibia & Fibula
Rt Femur & Tibula, Abdominal injury (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Struck by auto-truck (Duration).....yrs.....mos.....ds.

(Signed) J. S. H. Potter M. D.
(Coroner.)

12-25, 19 22 (Address) 508 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Herrang Ken	12-27, 19 22
20-UNDERTAKER	**ADDRESS**
Jack Lewis	1439 E. Balto St

N. B.—Every item of information should be carefully supplied. AGE must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70383

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. D70383

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 343 S. Fourteenth St., 26 WARD)

2-FULL NAME Infant Schaller

(a) RESIDENCE NO. 343 S. Fourteenth ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) Dec 8, 1922

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		15.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Inman Schaller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Inman Schaller
(Address) 343 S. 14th St

15 Filed DEC 25 1922 ROBERT R. KRAUTER, Registrar
Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1922, to Dec 23, 1922, that I last saw h alive on Dec 22, 1922, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. mos 15 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Adam Tod, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 26 22
20 UNDERTAKER	ADDRESS
Wendell J Lyford	00 E Fort

NOTE—Information should be carefully supplied. AGE must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D70384

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70384

CERTIFICATE OF DEATH.

REGISTERED NO. 159

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1220 Patapsco ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marman Catherin Ehart

(a) RESIDENCE. NO. 1220 Patapsco ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 25 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER August Ehart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Catherin Kemper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Catherin Ehart
(Address) 1220 Patapsco St

15 Filed DEC 25 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-24 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 1922, to Dec. 24, 1922, that I last saw h[illegible] alive on Dec 23, 1922, and that death occurred, on the date stated above, at 1 30 p m.

The CAUSE OF DEATH* was as follows:

Congenital Heart

(duration) — yrs. — mos. 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. C. Conser, M. D.

12-24, 1922 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a a Co — DATE OF BURIAL 12-25 1922

20 UNDERTAKER E & B Hartz — ADDRESS 115 E Mad St

mation should be carefully supplied. And it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70385

CERTIFICATE OF DEATH.

49

D70385

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 N. Dallas St ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Kelley

(a) RESIDENCE NO. 1811 N. Dallas St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Kelley

6 DATE OF BIRTH (month, day, and year): 5/9/1854

7 AGE: Years 68; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: M. Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Wm Kelley

(Address): 1811 N. Dallas St.

15 Filed DEC 25 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Seven months ago, 19 22, to Dec 22, 19 22,

that I last saw him alive on Dec 22, 19 22,

and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:

Cancer Eye

Seven months (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — Dr. Marcus

not immediately

Did an operation precede death? Date of Yesterday

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. Kelley, M. D.

Dec 25, 19 22 (Address) 1839 Bruns

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Cemetery Govans

DATE OF BURIAL: 12/26 1922

20 UNDERTAKER: George J. Ruth

ADDRESS: 1735 Harford Ave

N. B.—WRITE plainly, carefully supplied. AGE should be stated in years. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70386

101-001 D70386

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1714 Harford ave ST.: 9 WARD)

2-FULL NAME Martin F. Rohleder.

(a) RESIDENCE. NO. 1714 Harford ave ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Rohleder

6 DATE OF BIRTH (month, day, and year) 6/12/1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Martin Rohleder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Fannie Rohleder (Address) 1714 Harford Ave

15 Filed DEC 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1922, to Dec 22, 1922, that I last saw him alive on Dec 22, 1922, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W. Anderson, M. D.

, 19 (Address) 1714 N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	12/26/22 19
20 UNDERTAKER	ADDRESS
George J Ruth	1735 Harford Ave

mation should be carefully supplied. Avoid abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D70387

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70387

CERTIFICATE OF DEATH.

74001

REGISTERED NO.

1-PLACE OF DEATH Bon Secours Hospital

CITY OF BALTIMORE: (No. 20 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Jennie Dryden

(a) RESIDENCE NO. Bon Secours Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	59	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ex-Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Sam Dryden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. C. Rogers

(Address) 2 Augusta Ave

15 Filed DEC 25 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 22nd, 1922, to Dec 23rd, 1922, that I last saw her alive on Dec 23rd, 1922, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia - cva

c marked atrophy and undernutrition.

In Hospital: (duration) 0 yrs. 9 mos 17 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chief Of Omp clinical picture.

(Signed) O.C. Hauser (Intern) M. D.

, 19 (Address) Johns Hopkins Med. School

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Gen DATE OF BURIAL 12/26/22

20 UNDERTAKER Joseph A Farley ADDRESS Fulton & Fayette

N. B.—WRITE with pen and ink. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplexy

Binder

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70388

CERTIFICATE OF DEATH.

90 D70388

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 320 W. 28 St. 12 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Binder.

(Residence in Baltimore: No. 320 W. 28 st

52 St.; yrs., mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Dec 12, 1870 (Month) (Day) (Year)

7-AGE, 52 yrs. mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work housework.
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, James Sarlor

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Kenni

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. L. Binder

(Address) 320 W. 28 St

15-

Filed DEC 25 1922 191.... ROBERT R. KRAUTER, Registrar. Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 22, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

CAUSE OF DEATH* was as follows: Valvular disease of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner.) M. D.

Dec 24 1922 (Address) 1602 Rob

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery DATE OF BURIAL, Dec. 26, 1922

20-UNDERTAKER Henry Hoeck Son ADDRESS 1301 E Eager St.

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70389 90 D70389

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 N Washington ST., 7 WARD)

2-FULL NAME Lawrence A Mohr Sr

(a) RESIDENCE NO. 1032 N Washington ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): Oct. 19 1849

7 AGE: Years 73 | Months 2 | Days 5 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor 080

(b) General nature of Industry, business, or establishment in which employed (or employer): Pressing and Sewing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Lawrence A Mohr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Barbara Matt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Son & Mother (Address): 1032 N Washington

15 Filed DEC 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 24 1922

17 I HEREBY CERTIFY, That I attended deceased from June 6th, 1921, to December 24th, 1922, that I last saw him alive on Dec 23d, 1922, and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease of Heart. Hypertrophy of Heart

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at his Home 1032 Washington

Did an operation precede death? no Date of 1030

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Thomas J Dennis, M. D.

, 19 (Address) 1025 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Dec 27 1922

20 UNDERTAKER: Henry Hooch Son — ADDRESS: 1301 E Eager

Information should be carefully supplied. AGE should be given in YEARS. Exact statement of DISEASE or CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. NAME and RESIDENCE of INFORMANT is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70390

D70390

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 939 N. Castle ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Worrell

(a) RESIDENCE. NO. 939 N. Castle St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 5-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Worrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Hetzler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Alice Worrell (Address) 939 N. Castle st

15 Filed DEC 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1922

17 I HEREBY CERTIFY, That I attended deceased from March 19 22, to Dec 23, 19 22, that I last saw h~~im~~ alive on Dec 23, 19 22, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (contributory) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Dec 24 1922 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 26 1922
20 UNDERTAKER	ADDRESS
Henry Lutz	N. Broadway

information should be carefully supplied. Exact statement of facts is required, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified

Spec.—1-10-21—M&T—1500 Bks.

D70391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D70391

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 E Rogers ave ST., 21 WARD)

2-FULL NAME Sophia Elizabeth Grape

(a) RESIDENCE NO. 100 E Rogers ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 2 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 30th 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer) Public School

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER George Grape

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Charlotte Sanders

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Charlotte S. Church
(Address) 100 E Rogers ave Pimlico

DEC 25 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/23 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1922, to Dec. 23, 1922,

that I last saw her alive on Dec. 22, 1922,

and that death occurred, on the date stated above, at 730 P. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

Mitral Stenosis

(duration) yrs. 2 mos 13 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Auscultation findings

(Signed) H. M. Stevenson M. D.

(Address) 2733 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Dec 26th 1922

20 UNDERTAKER George Schelling & Sons

ADDRESS 1126 E Monument St

N. B.—WRITE plainly. All information should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70392

CERTIFICATE OF DEATH.

5-90 D70392

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 600 Fairmount St.; WARD) 5

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Wubbold

(Residence in Baltimore: No. & Same not in city St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, Unknown (Month) (Day), 1859 (Year)

7-AGE, 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar maker
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Herman Wubbold

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry J. Wubbold

(Address) 413 Spalding Ave.

15- Filed DEC 25 1922, 191.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 23 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) I find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Duration: yrs. mos. ds.

CONTRIBUTORY (Secondary)

Duration: yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Dec 24, 1922 (Address) 1609 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Dec. 26, 1922

20-UNDERTAKER C. W. Dill — ADDRESS 3109 Frederick Ave.

N. B.—Every item of information should be carefully supplied. AGE must be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70393

D70393

CERTIFICATE OF DEATH.

44

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3650 Morley Ave. ST., 40 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Wurm

(a) RESIDENCE. NO. 3650 Morley Ave. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Joseph Wurm

6 DATE OF BIRTH (month, day, and year): 12. 31. 47

7 AGE — Years: 74. Months: 11. Days: 21. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

037

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: R. Vogel.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs. Anna Benkert N. Eaton Ave

15 Filed DEC 25 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12. 22. 1922

17 I HEREBY CERTIFY, That I attended deceased from November 22 1922 to Dec. 22 1922, that I last saw h alive on Dec. 22 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyloric Orifice

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. A. Meyer M. D.

23. 1922 (Address) 1031 N. Carline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathederal

DATE OF BURIAL: Dec. 26 1922

20 UNDERTAKER: C. W. Dill

ADDRESS 3109 Frederick Ave

mation should be carefully supplied. Also that it may be properly classified. Exact statement of the CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF THE CAUSE OF DEATH IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70394

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70394

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 S. Sharp Street St. 23 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Smith

(a) RESIDENCE. No. 914 S. Sharp Streeet St. 23 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Gordon Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Spence.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Annie Smith
(Address) Gilessharp St.

15 Filed DEC 25 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dece25,22 19

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23rd 1922 to Dec. 25,22.. 19

that I last saw him alive on Dec. 25, 1922. 19

and that death occurred, on the date stated above, at 7.00 A. m.

The CAUSE OF DEATH* was as follows:

Streptococci Sore Throat, Septic infection.

About (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Probable Syphillis Neonatorium (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None.

Did an operation precede death? No Date of -

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) J. Gunson Courtney, M. D.

12/25 19 22 (Address) #908 S. Sharp Street.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Molenhun Cem	12/27 '22
20 UNDERTAKER	ADDRESS
Jno H. Ivadunis	141 N Hall St

mation should be carefully supplied. Avoid abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

D70395

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D70395

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 505 S. Gilmor St., 1 WARD)

2-FULL NAME Jacob D. Morrison

(a) RESIDENCE NO. 505 S. Gilmor ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 10, 1838

7 AGE: Years 84 | Months | Days | If LESS than 1 day ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): 030

(c) Name of employer: A. G. Co

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John F. Morrison

11 BIRTHPLACE OF FATHER (city or town) (State or country): A G Co Md

12 MAIDEN NAME OF MOTHER: Mary Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Del Md

14 Informant: Sarah Morrison (Address) 4621 Strickers St

15 Filed DEC 25 1922, 19 ... ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922 to Dec 22, 1922.

that I last saw h[illegible] alive on Dec 21, 1922

and that death occurred, on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:

(a) Chronic Interstitial Nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? No Date of V

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo. Keller M. D.

(Address) 1937 Gough St 12/23/22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon Cem. DATE OF BURIAL: Dec 26 1922

20 UNDERTAKER: Colt Funeral Co ADDRESS: 1 W. Pratt

N. B.—WRITE plainly. All information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70396

CERTIFICATE OF DEATH.

90 D70396

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4407 Pentwyst ave ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa H Stewart

(Residence in Baltimore: No. 4407 Pentwyst ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE,~~ ~~MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (~~Write the word.~~) Wdw

6-DATE OF BIRTH, May 16 (Month), 1846 (Day) (Year)

7-AGE, 76 yrs. 7 mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Nathaniel Nelcheon

11-BIRTHPLACE OF FATHER (State or Country), Gonnany

12-MAIDEN NAME OF MOTHER Bertha Fischo

13-BIRTHPLACE OF MOTHER (State or Country), Gonnany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Stewart

(Address) 1748 E Hoffman Ave

15- DEC 25 1922 ROBERT R. KRAUTER, Registrar.
Filed....., 191.....
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

Mrs. Louisa H. Stewart.

16-DATE OF DEATH, December 22, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased ~~from~~ 3 or 4 years ~~to~~, to Dec. 22" 1922, that I saw her alive on Dec. 22" 1922, and that death occurred, on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH* was as follows: For 3 or 4 yrs has been getting feebler, with valvular lesion of heart, arterio sclerosis, attacks of petit mal during both years mind has been failing, & mental derangement, was complete during last few weeks (Duration) ....yrs. ....mos. ....ds.

Death due to insanition, with pneumonia CONTRIBUTORY (Secondary) two days. (Duration) ....yrs. ....mos. ....ds.

(Signed) O. H. Hoffmann M. D.

12-22, 1922 (Address) 3402 Walbrook Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park. DATE OF BURIAL, Dec. 26, 1922

20-UNDERTAKER Babylon Funeral Dir. ADDRESS 1442 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

160436

HEALTH DEPARTMENT—CITY OF BALTIMORE

23 D70397

CERTIFICATE OF DEATH

D70397 DEATH Johns Hopkins Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No.) ST., 14 WARD)

2-FULL NAME Calain Wallenstein

(a) RESIDENCE NO. 2042 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 29, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Sidney Wallenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Rebecca Engleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Johns Hopkins Hospital (Address) Records

15 Filed DEC 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 20th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1922 to Dec. 20th, 1922, that I last saw him alive on Dec. 20th, 1922, and that death occurred, on the date stated above, at 9 35 A.m.

The CAUSE OF DEATH* was as follows:

Encephalitis (Epidemic)

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehren Louthans Co DATE OF BURIAL 12/26 1922

20 UNDERTAKER Jack Lewis ADDRESS 1709 E Baltimore

N.B. All information should be carefully supplied. AGE should be correctly classified. Exact statement of DISEASE or CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70398

D70398

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1626 E. Chase ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Silverman

(a) RESIDENCE. No 1626 E. Chase ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-16-22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Louis Silverman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Dubkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Silverman
(Address) 1626 E. Chase St

15 Filed DEC 25 1922 19.. ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/25th 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1922, to Dec 24, 1922

that I last saw him alive on Dec 24, 1922

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) D. H. Hometein, M. D.

12/25 1922 (Address) 733 Arcadia St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehren Herrington	12/25 19 22
20 UNDERTAKER Jacob Louis Weatherall	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be carefully supplied. Avoid abbreviations. TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D70399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D70399

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2039 W. Pratt ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Wasmuns,

(a) RESIDENCE NO. 2039 W Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed,~~ or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Louisa C. Wasmuns

6 DATE OF BIRTH (month, day, and year) Aug 30 1850

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
72	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Frederick Wasmuns

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Elizabeth Causey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Louisa C Wasmuns

(Address): 2039 W Pratt St

15 Filed DEC 25 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC 24 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 23, 1922 to Dec 24, 1922.

that I last saw h— alive on Dec 23, 1922.

and that death occurred, on the date stated above, at 5.40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Sclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E. O. Cruikshank M. D.

19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: London Park

DATE OF BURIAL: DEC 26 1922

20 UNDERTAKER: Geo W Little

ADDRESS: 2709 EDMONDSON AVE

DEC 24 1922

Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.
mation should be carefully supplied.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70400

CERTIFICATE OF DEATH.

106

D70400

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 N. Arlington ave ST.) (16 WARD)

2-FULL NAME Richard P. Cousins

(a) RESIDENCE. NO. 626 N. Arlington ave WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Cousins

6 DATE OF BIRTH (month, day, and year) Jan 9-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture cat.

(c) Name of employer Frank J. Murphy

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Philip Cousins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary McCarthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mary A. Cousins. 626 Arlington ave

15 DEC 25 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 23, 19 22, to Dec 23, 19 22, that I last saw h[illegible] alive on Dec 23, 19 22, and that death occurred, on the date stated above, at 3-A m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis over

(duration) yrs. ..... mos. 3 ds. 0

CONTRIBUTORY (Secondary) Pulmonary Emphysema

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

Dec 26, 19 22 (Address) 720 N. Monta[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Dec 26 1922

ADDRESS

20 UNDERTAKER F. A. Krause & Son 703 N. Howard

mation should be carefully supplied. Exact statement of occupa-
may be properly classified. Space for
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Dr. Jones M. D.
72 W. South ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70401 HEALTH DEPARTMENT—CITY OF BALTIMORE D70401

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 S. Charles St. 23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M. Marlet

(a) RESIDENCE. No. 1218 S. Charles St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 7th 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk (office) 009

(b) General nature of industry, business, or establishment in which employed (or employer) Packing-house

(c) Name of employer Thos. S. Myer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Henry F. Marlet

11 BIRTHPLACE OF FATHER (city or town) New York
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Lagen

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mr. Henry Marlet
(Address) 1218 S. Charles St.

15 Filed DEC 25 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25 1922, to Dec 21st 1922, that I last saw h alive on Dec. 21st 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease
(Bicuspid valve)

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Congestion of lungs + Stomach

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Emmie R. Browne, M. D.

Dec. 27th 1922 (Address) 1223 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Dec 26 1922

20 UNDERTAKER F. A. Krause & Son ADDRESS 703 Hanover

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Fallon

D70402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED No. D70402

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 N. Eutaw ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ellen Fallon

(Residence in Baltimore: No. 1124 N. Eutaw St. St.; 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1843 (Year)

7-AGE, 79 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country) Frederick Md.

PARENTS.

10-NAME OF FATHER, George Schnill

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Pheobus.

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sara Fallon

(Address) 1124 N. Eutaw

15- DEC 25 1922 ROBERT R. KRAUTER, Filed ....., 191... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 24 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 25 1914, to Dec 24 1922, that I saw h[illegible] alive on Dec 23 1922, and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia (Duration) yrs. mos. 10 ds.

(Signed) Jno Schleicher M. D.

Dec 27, 1922 (Address) 1025 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Frederick Md — DATE OF BURIAL, Dec 28 1922

20-UNDERTAKER H Fraley & Sons — ADDRESS 1821 N North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] important. See instructions on back of certificate.*

Spec.—1-10-21—M&T—1500 Bks.

D70403 362 Balto. City

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 101-001 D70403

1-PLACE OF DEATH — REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Johns Hopkins Hosp ST., 5 WARD)

2-FULL NAME Zeda Jasper

(a) RESIDENCE NO. 1417 Mulliken St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred hotel mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: Black — 5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug. 27-1921

7 AGE: Years 15 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): Child

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Jesrod Jasper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Mary M Boman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charleston

14 Informant Mary M Jasper (Address) 1417 Mulliken St

15 Filed DEC 25 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1922, to Dec 23, 1922, that I last saw he alive on Dec 23, 1922, and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy.

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Dec 26 1922

20 UNDERTAKER: Mrs R A Elliott — ADDRESS: 1725 Ashland Av

mation should be carefully supplied. Avoid abbreviations. Exact statement of occupation CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Powell

HEALTH DEPARTMENT—CITY OF BALTIMORE D70404

D70404

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

101-001

Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hosp St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Ina May Powell

(Residence in Baltimore: No. 1302 N. Spring St.; yrs.....mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Black	Single

6-DATE OF BIRTH. June (Month) 20 (Day) 1921 (Year)

7-AGE. 1 yrs. 6 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer)..... Child

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Albert Powell

11-BIRTHPLACE OF FATHER, (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER Agatha Forte

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agatha F. Powell

(Address) 1302 N. Spring St

15- DEC 25 1922 Filed..... 192..... ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 22 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

Autopsy at Hospital

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) J. H. Collins M. D. (Coroner)

12-23 192? (Address) 508 E. Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery | DATE OF BURIAL, December 26 1922

20-UNDERTAKER. Wm Robert Elliott | ADDRESS 1725 Arlington Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Space is very important. See instructions on back of certificate.

D70405

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70405

CERTIFICATE OF DEATH.

100-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawson Smith

(Residence in Baltimore: No. 922 E. Madison St.; yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: (Month) May (Day) 14 (Year) 1923

7-AGE: yrs. 4 mos. 8 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): Child

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Frederick Bailey

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Emma Smith

13-BIRTHPLACE OF MOTHER, (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Smith (Mother)

(Address) 922 E. Madison

15-

Filed DEC 25 1923 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: (Month) Dec (Day) 22 (Year) 1923

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an unknown (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said unknown (Inquest, autopsy or Inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Right sup. Bronchial Pneumonia

(Autopsy at Hopkins)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Fuller M. D.
(Coroner.)

12-23 1923 (Address) 5 E. Madison

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Laurel Cemetery DATE OF BURIAL: Dec 26 1923

20-UNDERTAKER: Mrs Robert Elliott ADDRESS 1725 Ashland Ave

N. B. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question is very important. See instructions on back of certificate.

Willie Jones

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70406

D70406

CERTIFICATE OF DEATH.

101-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1307 N Chapel St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Willie Jones

(Residence in Baltimore: No. 1307 N. Chapel St.; yrs., 8 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	Black	Single

6-DATE OF BIRTH. Apr (Month) 15 (Day) 1914 (Year)

7-AGE. yrs. 8 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Willie Jones

11-BIRTHPLACE OF FATHER, (State or Country). Florida

12-MAIDEN NAME OF MOTHER. Carrie McMillan

13-BIRTHPLACE OF MOTHER, (State or Country). Alabama

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie McMillan Jones

(Address) 1307 N. Chapel

15- Filed DEC 25 1922 ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 23 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia - Bronchial Lobar

(Duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Wallis M. D.
(Coroner.)

12-23 1922 (Address) 508 E. Monument

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Dec 23 1922

20-UNDERTAKER. Robert A Elliott ADDRESS 1723 Ashland Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Each item is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

70407
D70407

CERTIFICATE OF DEATH.

164

D70407

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Orleans ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernhard Blum

(a) RESIDENCE NO. 2000 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Blum

6 DATE OF BIRTH (month, day, and year): Oct 20 1837

7 AGE — Years: 85 — Months: 1 — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: Retired

(a) Trade, profession or particular kind of work: Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dort Knor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dort Knor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary Blum

(Address): 2000 Orleans

15 Filed DEC 26 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 24 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 11, 1922, to Dec 24, 1922, that I last saw him alive on Dec 20, 1922, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Senile Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Abm B Lurman M. D.

12/26/1922 (Address) 718 N Pulaski St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: Dec 26 1922

20 UNDERTAKER: John Ellrich — ADDRESS: 2005 Orleans

N. B.—WRITE PLAINLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in years, months and days. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

70408 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 70408

70408 CERTIFICATE OF DEATH. 38 D70408

D70408 REGISTERED NO.

1-PLACE OF DEATH Howard A Kelly Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST.: 14 WARD)

2-FULL NAME Stephen Cleon Allen

(a) RESIDENCE. No. 928 W. Pike St. Clarksburg W Va WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Rose Garrett Allen

6 DATE OF BIRTH (month, day, and year): Apr. 22, 1859

7 AGE: Years 63 Months 8 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): Rail Road
(c) Name of employer: Non-retired - 8 yrs. Clarksburg W. Va

073

9 BIRTHPLACE (city or town) (State or country): Clarksburg W. Va

PARENTS

10 NAME OF FATHER: Stephen Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harrison Co W. Va.

12 MAIDEN NAME OF MOTHER: Nancy Mayse

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bath Co. Va

14 Informant: Lynn Allen
(Address): Clarksburg W. Va

15 Filed DEC 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1922, to Dec 25, 1922 that I last saw him alive on Dec 23, 1922 and that death occurred, on the date stated above, at 3 20 P m.

The CAUSE OF DEATH* was as follows:
Myeloid Leukemia

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): Syphilis ? Wassermann Reac + +++
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood test.

(Signed) Grant E Ward, M. D.

, 19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Clarksburg W. Va. DATE OF BURIAL: Dec 27 1922

20 UNDERTAKER: Chas. H. Black ADDRESS: 742 W. North Ave

nation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70409

CERTIFICATE OF DEATH.

74001 D70409

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 854 West Baltimore St ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Schofield

(a) RESIDENCE NO. 854 West Baltimore St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph B. Schofield

6 DATE OF BIRTH (month, day, and year) Jan 23 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	72	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Bulach

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Joseph B. Schofield

(Address) 854 West Baltimore St

15 Filed DEC 26 1922, 19.. HENRY R. KRAMER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1922, to Dec 25, 1922, that I last saw her alive on Dec 25, 1922, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) — yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Grundler, M. D.

12/25/22 (Address) 517 Scott Street.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	Dec 27, 1922
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N Gilmor St

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70410

D70410

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No.) ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ennis

(a) RESIDENCE NO. 2203 Walbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah A Ennis

6 DATE OF BIRTH (month, day, and year): Jan 9 1837

7 AGE: Years 85; Months 11; Days 16; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Invest. Paying

(b) General nature of Industry, business, or establishment in which employed (or employer): for Estate

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Joseph J. Ennis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Teresa Pepper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hosp. Record

15 Filed DEC 26 1922 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 25 1922

17 I HEREBY CERTIFY, That I attended deceased from 6-30 1920 to 12-25 1922

that I last saw him alive on Dec 25 1922

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Dementia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

Dec 25, 1922 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Dec 27 1922

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 N. Balto St

Exact statement of DISEASES properly classified. ... mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASES ... TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70411

CERTIFICATE OF DEATH.

185 D70411

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Hollins St. ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Manning

(a) RESIDENCE NO. 1002 Hollins St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 10" 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	65	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Bernard Manning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Mamie Sullivan (Address) 1002 Hollins St.

15 Filed DEC 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23" 19 22

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1922, to Dec 23, 1922, that I last saw her alive on Dec 22, 19 22, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis. - 10 yr.
Pulmonary Oedema + 3 wks

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Insuff of Cir.

(duration) yrs 1 mos. 11 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw J Gambrill M. D.

12/23/19 22 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Dec 26 1922
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bolton St

Information should be carefully supplied. AGE should be correctly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D70412

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70412

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2857 W. North Ave. ST., 15 WARD)

2-FULL NAME George E. Houck

(a) RESIDENCE NO. 2857 W. North Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Delia F. Houck

6 DATE OF BIRTH (month, day, and year) Jan 8th, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer Penna R. R. Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER George H. Houck

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Arnold

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Mrs Delia F. Houck

(Address) 2857 W. North Ave.

15 Filed DEC 26 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1922, to Dec 24, 1922

that I last saw him alive on Dec 23, 1922

and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. — mos. ds.

CONTRIBUTORY (Secondary) Acut Endocarditis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Culbreth, M. D.

12/26/22 (Address) 2757 W. North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Dec 26th 1922

20 UNDERTAKER Bertram Moore

ADDRESS 1723 N. Lafayette

mation should be carefully supplied. AGE should be entered in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70413 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D70413

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N. Chapel ST. 6 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth C. Stoelbel

(a) RESIDENCE NO. 225 N. Chappel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Simon Stoelbel

6 DATE OF BIRTH (month, day, and year) Nov 15th 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

37

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS
10 NAME OF FATHER Wm. Loewer.
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER Frances Zang
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant Simon Stoelbel
(Address) 225 N. Chapel St.

15 Filed DEC 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1922, to Dec 22, 1922,
that I last saw h[illegible] alive on Dec 22, 1922,
and that death occurred, on the date stated above, at 10.05 a.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Arteriosclerosis
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)
(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John D. Gill M. D.
12/26, 1922 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer. DATE OF BURIAL: Dec 26th 1922

20 UNDERTAKER: Wendel Dippel & Son ADDRESS: 37 S. Conn. Ave

mation should be carefully supplied. AGE should be given. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70414

CERTIFICATE OF DEATH.

90

REGISTERED NO. D70414

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4107 Massachusetts Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J Rigby

(Residence in Baltimore: No. 4107 Massachusetts Ave St.; 68 yrs., 5 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July 12, 1854 (Month) (Day) (Year)

7-AGE, 68 yrs. 5 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Anton Dibring

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Fuches

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Stella Hamilet

(Address) 4107 Massachusetts Ave

15- Filed DEC 26 1922 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 24th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 18th 1922, to December 24 1922, that I saw h[illegible] alive on December 24th 1922, and that death occurred, on the date stated above, at 9 55 P m.

The CAUSE OF DEATH* was as follows:

[illegible] Gall stone disease

(Duration) ....yrs....mos. 20 ds.

CONTRIBUTORY (Secondary) Hypostatic congestion

(Duration) ....yrs....mos. [illegible] ds.

(Signed) [illegible] M. D.

Dec 26th, 1922 (Address) 1938 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem

DATE OF BURIAL, 12-27-, 1922

20-UNDERTAKER ROBERT BROOKS & SON

ADDRESS Calhoun & Hollins sts

N.B.—Every item must be answered so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D70415

D70415

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 Light St.; ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. McNeal

(Residence in Baltimore: No. 1430 Light St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Nov. (Month) 11 (Day), 1915 (Year)

7-AGE, 7 yrs. 1 mos. 14 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm. J. McNeal Sr.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Clara Nicholson

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. J. McNeal Sr.

(Address) 1430 Light St.

15- Filed DEC 26 1922 191 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 22nd (Day), 1922 (Year)

I HEREBY CERTIFY, That I attended deceased from Dec 2nd 1922, to Dec 22nd 1922, that I saw him alive on Dec. 22nd 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

(Signed) Harry Kleefield M.D.

Dec 25th 1922 (Address) 1224 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Dec. 26, 1922

20-UNDERTAKER Margaret J. Tynan ADDRESS 1422 Light St.

N.B.—Every question must be answered in this CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

K D70416

CERTIFICATE OF DEATH.

124 D70416

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318-E-Lanvale-St. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Kelley Galloway.

(a) RESIDENCE No. 318-E-Lanvale-St. ST., 12 WARD (Resident)
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 69 yrs. 10 mos. 2 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Grigfith Galloway

6 DATE OF BIRTH (month, day, and year) Feb-22-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physcian

(b) General nature of industry, business, or establishment in which employed (or employer) Medicine

(c) Name of employer self

9 BIRTHPLACE (city or town) Timonium
(State or country) Balto.Co.,Md.

PARENTS

10 NAME OF FATHER Acquilla Galloway

11 BIRTHPLACE OF FATHER (city or town) Timonium
(State or country) Balto.Co.,Md.

12 MAIDEN NAME OF MOTHER Mary ElizabethKelley

13 BIRTHPLACE OF MOTHER (city or town) Timonium
(State or country) Balto.Co.,Md.

14 Informant Mrs. Fannie G. Galloway, (wife)
(Address) 318-E-Lanvale-St., City

15 Filed DEC 26 1922 ROBERT R. KNAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 19th, 1922, to Dec 24th, 1922, that I last saw h[illegible] alive on 3 P.M. Dec 23, 1922 and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Cardiac Complications

(duration) Years ? yrs. mos 0 ds.

CONTRIBUTORY (Secondary) Chronic Colitis with Ulcers

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wilmer Brinton, M. D.

19 (Address) 1 W Lexington 6 Dec 22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sherwood Cem. Cockeysville Md

DATE OF BURIAL: Dec-26-2

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AV

N. B.—WHITE paper should be used for white persons and COLORED paper for colored persons. All information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This is very important.

D70417

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70417

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH: Pronounced Dead at Franklin Square Hospital (No. 22 Ward)

City of BALTIMORE:

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Frank A. Duchesney

(Residence in Baltimore: No. 647 Washington Boulevard St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Dec (Month) 12 (Day) 1881 (Year)

7-AGE. 41 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Stockman Iron
(b) General nature of industry, business, or establishment in which employed (or employer): Worker

9-BIRTHPLACE. (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: Chas Duchesney

11-BIRTHPLACE OF FATHER. (State or Country): Balto md

12-MAIDEN NAME OF MOTHER: Dorsey now

13-BIRTHPLACE OF MOTHER. (State or Country): " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Duchesney

(Address) 647 Washington Boulevard

15- Filed DEC 26 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 22 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage from Lungs (Duration) yrs. 2 mos. ds.

(Signed) James H. Kenton M. D. (Coroner.)

Dec 24 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Dec 26 1922

20-UNDERTAKER: The Undertakers — ADDRESS: 647 W Pratt St

N. B.—Every item of information should be given in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D70418

D70418

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., V WARD)

2-FULL NAME Charles Coughlin.

(a) RESIDENCE NO. 2041 Bank. ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 7 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~20~~	40.	4	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cost Driver

(b) General nature of industry, business, or establishment in which employed (or employer) 25

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Hugh Coughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Murdock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sahara Coughlin (Address) 2041 Bank St

15 DEC 26 1922 ROBERT R. KRAUTER, Registrar

Burial Permits Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1922, to Dec 23, 1922, that I last saw h[illegible] alive on Dec 23, 1922 and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Pneumonia x Heart Failure (duration) yrs. mos. 2. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross & Signs

(Signed) L. L. Scarborough M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Patricks Cemetery DATE OF BURIAL Dec 26 19 22

20 UNDERTAKER Lilly & Green ADDRESS 400 N Wolfe

mation should be carefully supplied. AGE should be given. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70419

CERTIFICATE OF DEATH.

3 N D70419

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 17 Ward)

2-FULL NAME Lena Allen

(a) RESIDENCE NO. 798 Druid Hill Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	29	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Lexington, (State or country) Virginia

PARENTS

10 NAME OF FATHER Frank Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records. (Address)

15 Filed DEC 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1922

17

I HEREBY CERTIFY, That I attended deceased from October 3, 1922, to December 22, 1922, that I last saw h alive on December 22, 1922, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Genito-urinary tuberculosis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Sputum

(Signed) Clyde Marie, M. D.

12/23/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Dec 26 1922

20 UNDERTAKER David Earhart — ADDRESS 916 Ca av

Name should be carefully supplied. AGE should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D70420

D70420

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST., 22 WARD)

2-FULL NAME James Williams

(a) RESIDENCE NO. 830 S. Eutaw ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Alfred Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ala.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) .....

14 Informant Hosp Records
(Address)

15 Filed ..... 19..... ROBERT R. KRAUTER, Registrar
DEC 26 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 22 1922

that I last saw him alive on Dec 21, 1922

and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 20 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Wassermann, Clyde McNeil

(Signed) ..... M. D.

12/26 1922 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Dec 19 2

20 UNDERTAKER David Exton

ADDRESS 916 Pa Ave

mation should be carefully supplied. Accurate and complete information is very important. See instructions on back of certificates. Exact statement of OCCUPATION should be properly classified, so that it may be CAUSE OF DEATH in plain terms,

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70421

CERTIFICATE OF DEATH.

57

D70421

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1325 N. Gilmor ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna S. Shermer

(a) RESIDENCE NO. 1325 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James M. Shermer

6 DATE OF BIRTH (month, day, and year): July 20. 1866

7 AGE: Years 56 Months 5 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

639

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Driver

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lavenia Maynard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: James M. Shermer (Address) 1325 N. Gilmor

15 Filed DEC 26 1922 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1922, to December 14 1922, that I last saw h[illegible] alive on Dec 24th, 1922, and that death occurred, on the date stated above, at 4.45 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis (duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Wm J Sherman M. D.

12/25, 1922 (Address) 1701 N. Eutaw ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem DATE OF BURIAL: Dec 28 1922

20 UNDERTAKER: Geo Cook Sr. ADDRESS

mation should be carefully supplied. AGE should be given. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Born 1837 Penn Av

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70422

CERTIFICATE OF DEATH.

101-001

D70422

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2551 Hardburgh St. (WARD) 13

2-FULL NAME John William Ruffell

(a) RESIDENCE NO. 2551 Hardburgh ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Nov 19 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	62	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ~~Bath~~ Balto

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Anselm Ruffell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germ

12 MAIDEN NAME OF MOTHER Anna Fatel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William J. Ruffell

(Address) 2551 Hardburgh Ave

15 DEC 26 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 22 1922 to Dec 24 1922

that I last saw h alive on Dec. 24 1922

and that death occurred, on the date stated above, at 11-30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 6 ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Isaac Brown, M. D.

Dec 25 1922 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Dec 27 1922

20 UNDERTAKER Wm Cook

ADDRESS 502 E. Balto

Exact statement of OCCUPATION should be carefully supplied. ALL blanks must be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D70423

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70423

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cherry Hill Mansion St. 25 WARD)

2-FULL NAME Albert K. Kearns

(a) RESIDENCE. No. Cherry Hill Mansion St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26 1922

7 AGE: Years —; Months 2; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John. Kearns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pittsburg Pa

12 MAIDEN NAME OF MOTHER Ida J Kroemer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Ida Kearns
(Address) Cherry Hill Mansion

Filed DEC 26 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 10 1922 to Dec 25 1922, that I last saw ~~him~~ alive on Dec 23 1922, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) no yrs. no mos. 3 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Cough.

(Signed) Sigmund Stumm, M. D.

Dec 25, 1922 (Address) Residence

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cem

DATE OF BURIAL: Dec 26 1922

20 UNDERTAKER: Jos Joerdens Son

ADDRESS: 2175 Pa

mation should be carefully supplied. Avoid abbreviations. Write plainly with pen and ink. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70424

D70424

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Glenwood Av WARD)

2-FULL NAME Margaret A. Craig

(a) RESIDENCE NO. 502 Glenwood Av WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 If Single, Married, Widowed, or Divorced: Married

5a If married, widowed, or divorced (or) WIFE of: Henry J Craig

6 DATE OF BIRTH (month, day, and year): 1-12-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (City or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Peter Black

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Margaret Keysdale

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mamie B. Gardner

(Address): 502 Glenwood Ave

15 Filed DEC 26 1922, 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1922, to Dec 24, 1922.

that I last saw h alive on Dec. 24, 1922

and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

unable to get history clear

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No clinical

What test confirmed diagnosis?

(Signed) H C Koer, M. D.

12-25 1922 (Address) 5700 York Rd. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cem

DATE OF BURIAL: 12/27 19 2

20 UNDERTAKER: Wm Cook

ADDRESS: 502 Glen

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be pro... classified. Exact statement of OCCUPATION is very important. See instructions on back of certific...

Spec.—1-10-21—M&T—1500 Blks.

D70425

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70425

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 ABBOTTSTON ST., 9 WARD)

2-FULL NAME LOUISA MILBURN,

(a) RESIDENCE No. 1609 ABBOTTSTON ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	WIDOWED

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of DR. JAMES A. MILBURN

6 DATE OF BIRTH (month, day, and year) NOVEMBER 10, 1860

7 AGE	62 Years	1 Months	14 Days	If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particulat kind of work HOUSEWORK

(b) General nature of industry, business, or establishment in which employed (or employer) AT HOME

(c) Name of employer

037

9 BIRTHPLACE (city or town) HOWARD COUNTY, MD.
(State or country) MARYLAND.

PARENTS

10 NAME OF FATHER JACOB KRAFT

11 BIRTHPLACE OF FATHER (city or town) UNKNOWN
(State or country) UNKNOWN

12 MAIDEN NAME OF MOTHER UNKNOWN

13 BIRTHPLACE OF MOTHER (city or town) UNKNOWN
(State or country) UNKNOWN

14
Informant NORMAN L. MANN.
(Address) 1609 ABBOTTSTON STREET.

15
Filed DEC 26 1922
ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 24, 1922.

17
I HEREBY CERTIFY, That I attended deceased from April, 1920, to Dec 24, 1922,
that I last saw her alive on Dec 24, 1922,
and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Arthritis Chr.

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) T. J. Kinzey, M. D.

12/25, 1922 (Address) 2700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL Dec 27, 1922

20 UNDERTAKER Fredk Lasahn & Sons — ADDRESS Fullerton

mation should be carefully supplied. Age should be stated.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Luis B. Culleny.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D70426

CERTIFICATE OF DEATH.

D70426

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1417 W Fayette St., 19 WARD)

2-FULL NAME Luis B Culleny

(a) RESIDENCE NO. 1417 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 10 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Wm Culleny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Louise Lightenberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Louis B Lightenberger (Address) 1417 W Fayette St

ROBERT M. KINSTLER

15 Filed DEC 26 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1922, to Dec 23, 1922, that I last saw h[illegible] alive on Dec 22, 1922 and that death occurred, on the date stated above, at 7.10 A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

, 19 (Address) 22 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Dec 26 1922
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette

mation should be carefully supplied. AGE should be stated [illegible]. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Register)

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D70427

D70427

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3411 Edendale Rd ST., 16 WARD)

2-FULL NAME Iola C Register

(a) RESIDENCE NO. 1018 W Lanvale ST., ... WARD 7

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua J Register

6 DATE OF BIRTH (month, day, and year) Sept 23 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md.

PARENTS

10 NAME OF FATHER Lewis Kellum.

11 BIRTHPLACE OF FATHER (city or town) Matthews

(State or country) Co. Virginia

12 MAIDEN NAME OF MOTHER Sarah J Fairbanks.

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Maine.

14 Informant (Address) J R McComas 3411 Edendale Rd.

15 Filed DEC 26 1922 19 ..... ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-25 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-25, 1922, to 12-25, 1922.

that I last saw h alive on ....., 19....,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Acute Heart Failure

Several Hours.

Unknown. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) Wm L Harryman, M. D.

, 19 (Address) 3409 Edendale Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount DATE OF BURIAL Dec 27 1922

20 UNDERTAKER John O Mitchell 1911 Lafayette ADDRESS

N. B. WARNING—The following information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70428

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70428

REGISTERED NO. 1291

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 406 Myrtle Ave ST., 17 WARD)

2-FULL NAME Mariah Gibson

(a) RESIDENCE NO. 406 Myrtle Av ST., 17 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 54 | Months Unknown | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of-work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Auburn

14 Informant: Chas. Gibson (Address) 406 Myrtle Ave

15 DEC 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 24 1922

17 I HEREBY CERTIFY, That I attended deceased from June, 1922, to Dec 24, 1922

that I last saw her alive on Dec 24, 1922

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal Disease

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. McRae, M. D.

, 19 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 20 December

20 UNDERTAKER: R L Parham — ADDRESS: 1220 Hanlon St

N.B. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

D70429

REGISTERED NO. D70429

D70429
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3210 Greenmount Ave. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta B. Condon

(a) RESIDENCE NO. 3210 Greenmount Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Condon

6 DATE OF BIRTH (month, day, and year) Feb. 18, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry C. Buschmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chester Condon
(Address) 3210 Greenmount Ave.

15 Filed DEC 26 1922 ROBERT R. KRAUTER, Register
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1922, to Dec 24, 1922,

that I last saw her alive on Dec 24, 1922

and that death occurred, on the date stated above, at 11 A.M. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus (terminal)

(duration) yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 4/14/22

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Daniel Fuller, M. D.

, 19 (Address) 1506 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuel Cemetery	Dec. 26, 1922
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway

N. B. ... should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70430

CERTIFICATE OF DEATH.

31 D70430

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kalal

(a) RESIDENCE NO. 1713 Cole st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0 10

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Kalal

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Carrie McKenzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M. T. H.

15 Filed DEC 26 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1922 to Dec. 25, 1922.

that I last saw her alive on Dec. 25, 1922.

and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, x-ray

(Signed) Flavio L. Delaglacca M. D.

12-26, 1922 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland Md — DATE OF BURIAL 12/26 1922

20 UNDERTAKER W. J. Perkins Son Hall — ADDRESS Balt

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70431

D70431

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 901 N. Port ST., 7 WARD)

2-FULL NAME John Lavicka Sr.

(a) RESIDENCE NO. 901 N. Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. — mos. — ds. How long in U. S., if of foreign birth? 48 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katharine

6 DATE OF BIRTH (month, day, and year): May 15, 1848

7 AGE: Years 74; Months 7; Days 9; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Bohemia Europe

PARENTS

10 NAME OF FATHER: Vitus Lavicka

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia Europe

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia Europe

14 Informant (Address): Catherine Lavicka 401 N Port St.

15 Filed DEC 26 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1922 to Dec 24 1922

that I last saw him alive on Dec 20 1922

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows: Endocarditis, Mitral Regurgitation

(duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? Gardenway

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. Wolf Rawlings M. D.

19 (Address) 500 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec 27 1922

20 UNDERTAKER: Finkler & Finkler — ADDRESS: 1739 Eager

N. B.—WRITE plainly. All items should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

D70432

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70432

CERTIFICATE OF DEATH.

113

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 404 So. Madeira St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thelma Hass

(Residence in Baltimore: No. 404 So. Madeira St; yrs., mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Dec (Month) 2 (Day) 1922 (Year)

7-AGE. ... yrs. ... mos. 22 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. Charles Hass

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Dora Hitchens

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Hass

(Address) 404 So. Madeira St

15- Filed DEC 26 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 24 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

15 minutes (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Intestinal Indigestion (Duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Norton M. D. (Coroner)

Dec 26 1922 (Address) Curtis Bay, Md

*State the Disease Causing Death, Or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St. Stanislaus Cem.	Dec. 26. 1922
20-UNDERTAKER.	ADDRESS
M. J. Sadowski	705 S. Ann St.

N. B.—Every item of information should be carefully ascertained and be properly classified. Exact statement of OCCUPATION may be important. If CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70433

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70433

CERTIFICATE OF DEATH.

67-001

REGISTERED NO.

1-PLACE OF DEATH South Balto Gen Hospital
1311 Light

CITY OF BALTIMORE: (No. 1311 Light St., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Whitson

(a) RESIDENCE NO. 1508 Bell St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) March 4 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Esplanade Apt.

(c) Name of employer

9 BIRTHPLACE (city or town) Anne Arundel Co
(State or country) Maryland

PARENTS

10 NAME OF FATHER Howard Whitson

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Estie Chaney

13 BIRTHPLACE OF MOTHER (city or town) Millersville
(State or country) Maryland

14 Informant Carrol Whitson
(Address) 1749 Hanover st

15 DEC 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 24 19 22

17 I HEREBY CERTIFY, That I attended deceased from October 31, 1922, to December 24 1922,
that I last saw him alive on December 24, 1922,
and that death occurred, on the date stated above, at 4 15 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Plumbism

(duration) 30 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John A. O'Connor M. D.

, 19 (Address) South Beds Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL Dec 28 1922

20 UNDERTAKER John F Donny

ADDRESS 715 Leg Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should read CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70434 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D70434

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hospital ST.) (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Amanda S. Collison

(a) RESIDENCE NO. 5005 Belleville Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Collison

6 DATE OF BIRTH (month, day, and year) Jan 7 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55 Yrs	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Alfred Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Susanna Cheyney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Md. General Hospital
(Address)

15 Filed DEC 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) dec 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922, to Dec 24, 1922, that I last saw her alive on Dec 24, 1922, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John H Wilkerson, M. D.

, 19 (Address) Md Gen Hosp. Path.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 12/28/22

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70435 CERTIFICATE OF DEATH. 44 D70435

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2 W. 20 Th St. ST.: 17 WARD)

2-FULL NAME Thomas Allen Millinan

(a) RESIDENCE. No. 2 W. 20 Th St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Millinan

6 DATE OF BIRTH (month, day and year) October 9th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

0 54

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo. L. Millinan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Sarah Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ella Millinan
(Address) 2 W 20th St

15 DEC 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) December 23rd 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20th, 1922, to Dec 23rd, 1922, that I last saw h alive on Dec 23rd, 1922, and that death occurred, on the date stated above, at 1910 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? All known tests

(Signed) Geo. W Thompson M.D.

12/27/22 (Address) 4016 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Dec 26 1922

20 UNDERTAKER E. A. Weidefeld Jr. — ADDRESS 30 E 23rd

mation should be carefully supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70436 160 9 40 a.m.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X49

D70436

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Allen

(a) RESIDENCE NO. Cambridge Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 weeks mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced ~~(or) WIFE of~~ HUSBAND of Rachael Allen

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Labor 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Unknown

14 JOHNS HOPKINS HOSPITAL.
Informant
(Address)

15 FILED DEC 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 7 - 1922 to Dec 23 1922

that I last saw him alive on Dec 23 1922

and that death occurred, on the date stated above, at 9 40 a m.

The CAUSE OF DEATH* was as follows:

carcinoma of bladder

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 13, 22

Was there an autopsy? no.

What test confirmed diagnosis? operation & P.E.

(Signed) Ira Luther Houghton, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md — DATE OF BURIAL Dec 26 1922

20 UNDERTAKER Chas Robert & Sons — ADDRESS 1725 Eutaw

mation should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dec 0290

Spec.—1-10-21—M&T—1500 Blks.

D70437

D70437 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

131

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 202 Cedar Ave. ST., 27 WARD)

2-FULL NAME Edna C. Shugars

(a) RESIDENCE NO. 202 Cedar Ave. ST., 27 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clayton R. Shugars

6 DATE OF BIRTH (month, day, and year) July 22 - 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Lancaster
(State or country) Penna.

PARENTS

10 NAME OF FATHER Aaron Specht

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penna.

12 MAIDEN NAME OF MOTHER Emma C. Rahauser

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Penna.

14 Informant Clayton R. Shugars
(Address) 202 Cedar Ave.

DEC 26 1922 ROBERT R. KRAUTER,
Filed ..... 19 ..... Registrar

Burial Permit Cl... Date

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1922, to Dec. 23, 1922, that I last saw h[illegible] alive on Dec. 28, 1922, and that death occurred, on the date stated above, at 11:10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's disease

(duration) yrs. 3 mos 8 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Gibson Parlin, M. D.

12-26, 1922 (Address) 422 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Dec. 27 1922

20 UNDERTAKER Horace A. Burgee — ADDRESS 3631 Falls Rd.

N. B.—WRITE PLAINLY. The items of information should be carefully supplied. AGE should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70438 HEALTH DEPARTMENT—CITY OF BALTIMORE D70438

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE—(No.) 1934 Mt. Royal Avenue (St.) (14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward F. Nicholand

(a) RESIDENCE NO. 1934 Mt. Royal Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Nicholand

6 DATE OF BIRTH (month, day, and year) Sept. 30, 1837

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
85	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 054

(b) General nature of industry, business, or establishment in which employed (or employer) Practice of Medicine

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Arthur Nicholand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Edward F. Nicholand

(Address) 1934 Mt Royal Terrace

15 Filed DEC 26 1922, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 24 19 22

17 I HEREBY CERTIFY, That I attended deceased from October 27, 1922, to December 24, 1922, that I last saw h[illegible] alive on December 23, 1922, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Entero-colitis

(duration) 30 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Edward F. Nicholand, M. D.

, 19 (Address) Stafford Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 12/26 1922

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

Spec.—1-10-21—M&T—1500 Bks.

D70439 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70439

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 17

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Lohmeyer

(a) RESIDENCE NO. 2827 Guilford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Wm. E. Lohmeyer

6 DATE OF BIRTH (month, day, and year) Aug. 13, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Haberdasher

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. H. Lohmeyer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elise Moehlick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. Carl Lohmeyer
(Address) 109 W. 29th St.

15 DEC 26 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) December 25th 1922

17 I HEREBY CERTIFY, That I attended deceased from December 21st, 1922, to December 25th, 1922, that I last saw him alive on December 23rd, 1922, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis, ruptured

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Dec. 21st

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) J. M. H. Finney Jr. M. D.

Dec 25th 1922 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 12/26 1922

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70440

CERTIFICATE OF DEATH.

1675-002 D70440

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1133 N. Gilmor ST., 16 WARD)

2-FULL NAME Mary A. Brown

(a) RESIDENCE NO. 1133 N. Gilmor ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 80		--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Attleboro (State or country) Massachusetts

PARENTS

10 NAME OF FATHER -------- Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Ann --------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Victor H. Power

(Address) 718 N. Charles St.

15 Filed DEC 26 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

Via Penn. Railroad, Escort - Victor H. Power

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 1922

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to Dec 24, 1922, that I last saw h alive on Dec 24, 1922, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) ... yrs. 5 mos 24 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. J. Huckabee Jr, M. D.

Dec 25 1922 (Address) 632 Gorsuch ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Attleboro, Massachusetts

DATE OF BURIAL 12/26 1922

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D70441

CERTIFICATE OF DEATH

100-001 D70441

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1715 E Preston ST.: 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Margaret P Rorsam

(Residence in Baltimore: No. 1715 E Preston St.; yrs. 3 mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word):

6-DATE OF BIRTH: September (Month) 5 (Day), 1922 (Year)

7-AGE: yrs. 3 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): Balto md

PARENTS

10-NAME OF FATHER: Adam P Rorsam

11-BIRTHPLACE OF FATHER (State or country): Balto

12-MAIDEN NAME OF MOTHER: Margaret E Rorsam

13-BIRTHPLACE OF MOTHER (State or country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Adam J Petersam

(Address) 1715 E Preston St

15 Filed DEC 26 1922 ROBERT R. KRAUTER, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Dec. (Month) 26 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November, 1922, to Dec 26 1922, that I saw h[illegible] alive on Dec 25, 1922, and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Bronchitis.

1 Bronchitis (Duration) yrs. 1 mos. 15 ds

Contributory (SECONDARY) Pneumonia (Duration) yrs. mos. 2 ds.

(Signed) Frank Bluemer M. D.

Dec 26, 1922 (Address) 1500 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Dec. 27 1922

20-UNDERTAKER: Henry Horch Son — ADDRESS: 1301 E Eager St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70442 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D70442

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 E. Eager ST., 10 WARD)

2-FULL NAME August P. Gabsinger

(a) RESIDENCE NO. 1407 E Eager ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

N. B. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of the late Elizabeth Gabsinger

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	84	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 014

(b) General nature of industry, business, or establishment in which employed (or employer) Woodworker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. August A. Gabsinger

(Address) 1407 E. Eager St

15 Filed DEC 26 1922 ROBERT R. KRAUTER, Burial Permit Clerk Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25 1922 to Dec. 25 1922

that I last saw h[illegible] alive on December 25 1922

and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Ages

(duration) Chronic Bronchitis yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Louis H. A. Meyer M. D.

12/26, 1922 (Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Dec. 28 1922

20 UNDERTAKER Henry Hoeck Son ADDRESS 1301 E Eager

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70443

D70443

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1031 Harford Ave ST., 10 WARD)

2-FULL NAME Elizabeth Gorsuch

(a) RESIDENCE NO. 1031 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Silas W. Gorsuch

6 DATE OF BIRTH (month, day, and year) March 10-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Bernard McMahon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Lilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Silas Gorsuch

(Address) 1031 Harford Ave.

15 Filed DEC 26 1922 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1922.

17 I HEREBY CERTIFY, That I attended deceased from Dec 6 d 1922 to Dec 25 d 1922

that I last saw her alive on Dec 24 d 1922

and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) L. McParker M. D.

12/26/1922 (Address) 1114 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Dec 27 1922

ADDRESS

20 UNDERTAKER H. C. Wiedefeld 914 Fremont

mation should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70444

HEALTH DEPARTMENT--CITY OF BALTIMORE

D70444

CERTIFICATE OF DEATH

101-001

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1309 Richardson ST. 24 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Nicholas Oswald

(Residence in Baltimore: No. 1309 Richardson St.: yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Dec. 23, 1866 (Month) (Day) (Year)

7 AGE: 56 yrs. 0 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Bricklayer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Austria Hungary

PARENTS

10 NAME OF FATHER: Nicholas Oswald

11 BIRTHPLACE OF FATHER (State or country): Austria Hungary

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Austria Hungary.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Oswald

(Address) 1309 Richardson

15. Filed DEC 26 1922, 191

Robert P. Harrison,
Burial Permit Clerk.
REGISTRAR

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December 24, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1922, to Dec 25 1922, that I saw him alive on Dec 24, 1922 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Thos F Sheehan M. D.

12/26, 1922 (Address) 2878 Hanford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Cross A.A.C. DATE OF BURIAL: Dec 27, 1922

20 UNDERTAKER: Margaret Flynn ADDRESS: 427 Fulton

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70445

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 Mulliken ST.: 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Noah Hilson

(a) RESIDENCE. No. 1610 Mulliken ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

mation should be carefully supplied. Avoid abbreviations. Write plainly. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 44 Months Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): O'Neill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Pierella Freeman

(Address): 1610 Mulliken St

15 Dated ... 19 ... E. Parrish, Registrar

DEC 26 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922, to Dec 22, 1922, that I last saw him alive on Dec 21, 1922, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

Satisfactory (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

12. 23. 1922 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JNS HOPKINS HOSPITAL	12/26 1922
20 UNDERTAKER	ADDRESS
Commissioner Health,	

1761 THE MORGUE.

D70446 HEALTH DEPARTMENT—CITY OF BALTIMORE D70446

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 508 Pearl St. St. 17 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Smith

(Residence in Baltimore: No. 508 Pearl St. St.; yrs. 54 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Sngl

6-DATE OF BIRTH, about (Month) (Day) 1868 (Year)

7-AGE, 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housework
(b) General nature of industry, business, or establishment in which employed (or employer), 0

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eleanora Holmes

(Address) 504 Pearl St.

15- Robert P. Harrison,

Dec 26 1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 14, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

6 wks. (Duration) yrs. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. A. J. Hennessy, M. D. (Coroner)

Dec 15, 1922 (Address) 2802 Eutaw Pl.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 12/26 1922

20-UNDERTAKER, ADDRESS

JOHNS HOPKINS HOSPITAL Compulsory Entry

1076 THE MORGUE.

NOTE—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70447

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70447

164

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 N. Patterson Park Ave. WARD 7)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick A. Fichte.

(a) RESIDENCE NO. 813 N. Patterson Park Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cecilia Fichte

6 DATE OF BIRTH (month, day, and year) Jan 9 1828

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	94	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) (Retired)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Karl Fichte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. J. L. Reibetanz (Address) 813 N. Patterson Park Ave

15 Filed ..... 19 ..... Robert P. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 25, 1922, to Dec 25th, 1922, that I last saw him alive on Dec 24th, 1922, and that death occurred, on the date stated above, at 5 05 A. m.

The CAUSE OF DEATH* was as follows:

Old Age

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ✓

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) August Horn, M. D.

, 19 (Address) 48 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Dec 27th 1922

20 UNDERTAKER H. Sander Sons

ADDRESS 1710 Eastern Ave

N. B.—WHITE PENCIL, WITH CARBON. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

261922 Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D70448

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70448

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Arondale Ave. (Near Park Heights Ave.) ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie M. Funk.

(a) RESIDENCE NO. Arondale Ave. near Park Heights Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Harvey J. Funk.

6 DATE OF BIRTH (month, day, and year) Aug. 4, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	61	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jacob Hanf.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown 12/25. 19 22

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Catherine Thumpt (Address) 325 Scott St

15 Filed ....., 19 .....

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24, 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1922, to Dec. 24, 1922.

that I last saw h— alive on Dec. 24, 1922.

and that death occurred, on the date stated above, at 8 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John D. Quinn M. D.

(Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL 12/27 1922

20 UNDERTAKER Wm Cook — ADDRESS 502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

261922

Spec.—1-10-21—M&T—1500 Blks.

D70449

HEALTH DEPARTMENT—CITY OF BALTIMORE D70449

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Club Road ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lan Vert Klinefelter

(a) RESIDENCE NO. 207 Club Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 89 yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Hooper Klinefelter

6 DATE OF BIRTH (month, day, and year): Oct 27. 1833

7 AGE — Years: 89 — Months: 1 — Days: 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Henry K Klinefelter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Eliza Mayberry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Ella K. Folsom

(Address) 207 Club Road

15 Filed ., 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 25 1922

17 I HEREBY CERTIFY, That I attended deceased from December 12 , 1922 , to Dec. 25 , 1922 ,

that I last saw him alive on Dec. 24 , 1922 ,

and that death occurred, on the date stated above, at 5.50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Unknown

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Lobar Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At his home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination of symptoms

(Signed) Charles Gatch, M. D.

Dec 25. 1922 (Address) 1116 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount — DATE OF BURIAL: Dec. 27 1922

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W. Fayette St.

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D70450 HEALTH DEPARTMENT—CITY OF BALTIMORE D70450

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Bailey Ave ST.: 2nd WARD)

2-FULL NAME James H. J Slavin

(a) RESIDENCE. No. 1211 Bailey Ave ST., 2nd WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Slavin

6 DATE OF BIRTH (month, day, and year): 7-[illegible]-1851

7 AGE: Years 71 Months — Days — If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Patk Slavin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Flute

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs Slavin Verona Park

15 Filed DEC 26 1922, 19 Robt F. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/24/22.

17 I HEREBY CERTIFY, That I attended deceased from 12/21/22, 19 . to 12/24/22, 19 . that I last saw him alive on 12/12/22, 19 and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Myocarditis, (duration) Drink Known yrs. mos. ds.

CONTRIBUTORY (Secondary) Cellulitis of Left hand & forearm (duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Edward Joyce M. D.

12/26, 19 22 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catholic Cem

DATE OF BURIAL: 12/26 19 22

20 UNDERTAKER: J. F. Tabler & Sons

ADDRESS: 1315 Eight Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70451

HEALTH DEPARTMENT—CITY OF BALTIMORE D70451

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Md Gen Hospital ST., WARD)

2-FULL NAME William V Hughes

(a) RESIDENCE NO. 1331 Mt Royal Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wte

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE: Years 50 | Months — | Days — | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 166

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER John Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER Mary J.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Md Gen Hospital

15 Filed 19 Rob. V. P. Harrison Registrar

DEC 26 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 19 22 to Dec 24, 19 22

that I last saw h(im) alive on Dec 24, 19 22

and that death occurred, on the date stated above, at 11.05 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J H Wilkerson M. D.

, 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem — DATE OF BURIAL: 12/27 1922

20 UNDERTAKER: J. F. Talley Home — ADDRESS: 1318 Eutaw St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70452

D70452

CERTIFICATE OF DEATH.

44

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2516 E. Monument ST., 7 WARD)

2-FULL NAME Minnie Josephine Langhurst

(a) RESIDENCE NO. 2516 Monument ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) Married

5a If married, widowed, or divorced (or) ~~HUSBAND OF~~ WIFE of Chas L. Langhurst

6 DATE OF BIRTH (month, day, and year) June 15-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	42	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles L. Langhurst
(Address) 2516 Monument E

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1922, to Dec 23, 1922,

that I last saw her alive on Dec 23, 1922,

and that death occurred, on the date stated above, at 4.25 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Intestines

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia Croupous

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward J. Leonard M. D.

12/24 1922 (Address) 418 N. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL Dec 27 1922

20 UNDERTAKER Lilly & Son

ADDRESS 403 S. Mott St.

DEC 26 1922

ROBERT F. HARRISON,
Burial Permit Clerk.

PHYSICIAN ... CAUSE OF DEATH ... TION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of

D70453

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70453

CERTIFICATE OF DEATH.

74-001

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 5212 York Road ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rachel E. Spencer

(Residence in Baltimore: No. 4907 York Road St. 29 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6-DATE OF BIRTH, Aug. (Month) 12 (Day), 1866 (Year)

7-AGE, 56 yrs. 4 mos. 13 ds.

If LESS than 1 day, ...hrs, or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country): Harford Co. Md.

PARENTS.

10-NAME OF FATHER: Thomas A. Amoss

11-BIRTHPLACE OF FATHER (State or Country): Harford Co. Md.

12-MAIDEN NAME OF MOTHER: Angeline V. Fetherill

13-BIRTHPLACE OF MOTHER (State or Country): Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Philip E. Spencer

(Address) 4907 York Road.

15- DEC 26 1922, 191 ..... Registrar.

Robert P. Harrison, Deputy Vital Records Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 25 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest and-
[illegible] find that said deceased came to death on the day stated above.
(Autopsy or Inquiry)
The CAUSE OF DEATH* was as follows:

@ Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
(Coroner.)

Dec 26, 1922. (Address) 363 [illegible] Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loptown Harford Co Md DATE OF BURIAL, Dec 27 1922

20-UNDERTAKER: Horace F. Burgee ADDRESS 363 Falls Rd.

C.R. 4261922

Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should be careful in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70454

CERTIFICATE OF DEATH.

181-001

D70454

REGISTERED NO. C

(PLACE OF DEATH) 2624 Shroeder Field Hosp. 21 WARD)

CITY OF BALTIMORE (No. 2624 Shroeder Field Hosp. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Henry Mueller

(Residence in Baltimore: No. 1112 Sargeant St

~~Ref~~ yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Nov (Month) 4 (Day), 1889 (Year)

7-AGE, 33 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Walter Mueller

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Amanda Annan

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma L. Mueller

(Address) 1112 Sargeant St

15-

Filed ....., 191.... Registrar.

Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 27 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) found that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Ill Gas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) ds.

(Signed) Wilson Paul M. D.
(Coroner.)

(Address) 19 W Fayette St Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore

DATE OF BURIAL, Dec 29, 1922

20-UNDERTAKER H. M. Cook

ADDRESS, 622 Eutaw

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

G26 1922 372

D70455

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003

D70455

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Josephs Hosp St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Frederick Armstrong

(Residence in Baltimore: No. 4922 Harford Road St; yrs., 45 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Dec 25, 1862
(Month) (Day) (Year)

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Foreman of
(b) General natnre of industry, business, or establishment in which employed (or employer). Labor

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, John Armstrong

11-BIRTHPLACE OF FATHER. (State or Country), England

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs John Brosch

(Address) 4922 Harford Ave.

15- DEC 27 1922

ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Automobile accident — Nov. 8, 1922)
Broncho-Pneumonia.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pressure ulcer from [illegible]

(Duration) yrs. mos. ds.

(Signed) J. S. Wallis M. D.
(Coroner.)

12-26 1922 (Address) 5.0.8 E. Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Holy Redeemer Cemtery Dec 27, 1922

20-UNDERTAKER. ADDRESS
George J Ruth 1134 Harford Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

"Pt Tubia

Brotate ... q ... R Humum,

Immigrati Dutched Lue 26/22 8 30 Pa

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

D70456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 11-001

D70456

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 Grindall Ct. ST. 22 WARD)

2-FULL NAME Frank Carpenter

(a) RESIDENCE NO. 725 Grindall Ct. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt Carpenter

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 40

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) — 070

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Agnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William Agnes
(Address) 1214 Druid alley

15 DEC 27 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 5, 19 22, to Dec 21, 19 22,

that I last saw h alive on Dec 21, 19 22,

and that death occurred, on the date stated above, at 4.40 m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. T. Smith, M. D.

, 19 (Address) 109 N. Eu St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Dec. 27, 1922

20 UNDERTAKER Jno H. Toadvine — ADDRESS 142 Wilkens St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70457

CERTIFICATE OF DEATH.

90 D70457

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Henry Julius

(a) RESIDENCE No. ..... ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: About 45(?) — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant ..... (Address) Bay View Hosp.

15 Filed DEC 27 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22nd 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922, to Dec 22 1922

that I last saw him alive on Dec 22 1922

and that death occurred, on the date stated above, at 5.20 p m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy C

(Signed) Clyde McKee M. D.

1922 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Dec 27 1922

20 UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

Spec.—1-10-21—M&T—1500 Bks.

D70458

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70458

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 572 W. Preston ST., 19 WARD)

2-FULL NAME Baby King

(a) RESIDENCE NO. 572 W. Preston ST., 17 WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS BLANK MUST NOT BE FOLDED. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 22-1922

7 AGE — Years: ~~None~~ — Months: ~~None~~ — Days: ~~Stillborn~~ — If LESS than 1 day 15 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Lewis King

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila. Pa

12 MAIDEN NAME OF MOTHER: Georgia Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. City

14 Informant: Georgia King

(Address) 572 W. Preston St

15 Filed DEC 27 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/23 1922

17

I HEREBY CERTIFY, That I attended deceased from 12/22, 1922, to 12-23, 1922, that I last saw h in alive on 12-22, 1922, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. McRae, M. D.

, 19 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 12/27/1922

20 UNDERTAKER: Samuel Hemsley — ADDRESS: 578 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70459

CERTIFICATE OF DEATH.

129 D70459

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 W. Cross ST., 21 WARD)

2-FULL NAME Margaret Dannettel

(a) RESIDENCE NO. 1220 W. Cross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED OUT COMPLETELY. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Wm. H. Dannettel

6 DATE OF BIRTH (month, day, and year): May 12-1855

7 AGE: Years 67 Months 7 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: W. H. Dannatell

(Address) 1220 W. Cross

15 DEC 27 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 24 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1916, to Dec 24, 1922, that I last saw h[illegible] alive on Dec 24, 1922 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis + Valvular insufficiency

(duration) 6 yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Auricular fibrilation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? not

What test confirmed diagnosis? usual tests

(Signed) H E Krupp M. D.

Dec 25, 1922 (Address) 1002 N. Zanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Dec 27 1922

20 UNDERTAKER: Wm J. Pickrell & Sons

ADDRESS: Northdale

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70460

D70460

CERTIFICATE OF DEATH.

47

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2315 E. Hoffman ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rula Harrington

(a) RESIDENCE NO. 2315 E. Hoffman ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: A. C. Harrington

6 DATE OF BIRTH (month, day, and year): Mar. 22, 1859

7 AGE: Years 63 | Months 9 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 639

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: John M. Sheppard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Virginia Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Florence Cammon

(Address) 2315 E. Hoffman St.

15 DEC 27 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 26 1922

17 I HEREBY CERTIFY, That I attended deceased from June 12 1922 to Dec 26 1922

that I last saw her alive on Dec 25 1922

and that death occurred, on the date stated above, at 12.15 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory Paralysis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Cancer of Breast

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Objective Signs

(Signed) U. S. Harker M. D.

Dec 26 1922 (Address) 1301 N Pat Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Marion, Va — DATE OF BURIAL: Dec 27 1922

20 UNDERTAKER: Wm Pickens Sons — ADDRESS: Norfolk Va

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70461

CERTIFICATE OF DEATH.

74-001

D70461

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 N. Caroline St. St., 6 Ward)

2-FULL NAME Sarah Wilkinson

(a) RESIDENCE No. 226 N. Caroline St. St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert O Wilkinson

6 DATE OF BIRTH (month, day, and year) June 20 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	61	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Robert O. Mumma

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Hall

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mr. Harry Wilkinson (Address) 226 N. Caroline St.

15 Filed DEC 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12 - 25 1922

17 I HEREBY CERTIFY, That I attended deceased from June. 10, 1919, to Dec. 25, 1922.

that I last saw h[e] alive on Dec 25, 1922. and that death occurred, on the date stated above, at 4 45 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Uterus. Scirrus (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. D. Morgan M. D.

12/26, 1922 (Address) 14 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL 12/28 1922

20 UNDERTAKER J. Wm. McCully

ADDRESS 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. mation should be carefully supplied. so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70462

CERTIFICATE OF DEATH

117

D70462

1-PLACE OF DEATH Hebrew Home & Relief Society

CITY OF BALTIMORE: (No. Monument St. & Caldwell Ave. St.; 5th (WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gregori Jakoreuk

(Residence in Baltimore: No. 1109 E Lombard St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, January, 1 (Month) (Day) (Year)

7-AGE, 38 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. Fyodan

(Address) 319 S. Eden St

15- Filed DEC 27 1922, 191.... ROBERT R. KRAUER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 12 / 24, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/9/22 191 , to 12/24/22 191 , that I saw h im alive on 12/24/22 191 , and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute Hypostatic Pneumonia

..... (Duration) ....yrs. ....mos. 9 ds.

(Signed) A. Stolar Lowenthal M. D.

12/24/22 191.. (Address) Hebrew Home

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1109 E. Lombard st

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery — DATE OF BURIAL, 12/27..., 1922

20-UNDERTAKER A. Levinson & Bro — ADDRESS 1127 E Baltimore St.

N. B.—Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-19-21—M&T—1500 Blks.

D70463

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70463

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH U.S. Veterans Hospital #56, Ft McHenry, Md..

CITY OF BALTIMORE: (No. ST.. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Bell,

(a) RESIDENCE No. 704 Sterling St., Baltimore ST. Md.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Bell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	28	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital Records Ft. McHenry, Md..

15 Filed DEC 27 1922 ROBERT R. KRAUTER, Burial Permit Clerk (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1922 to Dec. 24, 1922, that I last saw him alive on Dec. 24, 1922, and that death occurred, on the date stated above, at 7.25 P.m.

The CAUSE OF DEATH* was as follows:

Charonic Valvular Heart Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) -- (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Physical & Clinical findings

(Signed) H.B. Lusk Surgeon (R) M. D.

12/24/1922 (Address) Ft. McHenry, Md..

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery — DATE OF BURIAL 12/27 1922

20 UNDERTAKER D. Furman & Bro — ADDRESS 1127 E Baltimore St

N. B.—WRITE PLAINLY, WITH INK AND IN PENCIL. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70464

D70464

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #803-Hamilton-Terrace ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Emily Potter.

(a) RESIDENCE NO. #803-Hamilton-Terrace ST., 11 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 73 yrs. 7 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of WilliamSamuelPotter

6 DATE OF BIRTH (month, day, and year) May-12-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	73	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) West Point
(State or country) New York

PARENTS

10 NAME OF FATHER Isaac S.K. Reeves

11 BIRTHPLACE OF FATHER (city or town) Charleston
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Annie D. Read

13 BIRTHPLACE OF MOTHER (city or town) NewCastle
(State or country) Delaware

14 Informant MissMarianL. Potter (daughter)
(Address) #803-HamiltonTerrace, City.

15 Filed DEC 27 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/26 1922

17

I HEREBY CERTIFY, That I attended deceased from 12/22/22, 1922, to 12/26, 1922,

that I last saw h[er] alive on 12/26, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

many (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 31 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

12/27, 1922 (Address) 1004 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Dec-27-22

20 UNDERTAKER STEWART & MOWEN COMPANY
WILLIAM F. WOODEN, Successor

ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 74-001 D70465

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1244 E Fayette St ST., 5 WARD)

2-FULL NAME Sarah Klitzner

(a) RESIDENCE No. 1244 E Fayette St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
X	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Simon Klitzner

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levin (Address) 1439 E Baltimore St

15 Filed DEC 27 1922 19 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/26 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1922, to Dec 26, 1922, that I last saw h[illegible] alive on Dec 26, 1922, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. H. Hornstein, M. D.

12/27, 1922 (Address) 733 Arguello St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehren Rosedale	12/27 1922
UNDERTAKER	ADDRESS
Jack Levin	1439 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT IN FULL. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Baby Chase

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70466

CERTIFICATE OF DEATH. 100-001

D70466

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 898 Boyd St ST., 18 WARD)

2-FULL NAME Babie Chase

(a) RESIDENCE NO. 898 Boyds ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 Mos. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 18 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	Mths		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Eugene Chase.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bessie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eugene Smith

(Address) 898 Boyd St

15 Filed DEC 27 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/25, 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 23, 1922, to Dec. 25, 1922, that I last saw him alive on Dec. 25, 1922, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) over

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical Findings.

(Signed) A. Lee Forster, M. D.

Dec. 19 (Address) 2868 Lyndhurst Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Dec 27 1922

20 UNDERTAKER: Brown & Funsands Schuster — ADDRESS 1140 N.

Spec.—6-6-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70467

D70467

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Pierce ST.: 18 WARD)

2-FULL NAME Willie May Chase

(a) RESIDENCE. NO. 911 Pierce ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1921

7 AGE — Years: — Months: 18 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: Bates Md

9 BIRTHPLACE (city or town) (State or country): Bates Md

PARENTS

10 NAME OF FATHER: Willie Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Chase
(Address): 911 Pierce St

15 Filed DEC 27 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 25 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 22, to Dec 25 22,

that I last saw h... alive on Dec 25 22,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia
over

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Pulm Acdema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Norwood, M. D.

Dec 26, 1922 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Dec 27 1922

20 UNDERTAKER: Brown & Tuckman — ADDRESS 114 N Schroeder St

D70468

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70468

CERTIFICATE OF DEATH.

X 181-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2624 Stratford Ave St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mary Edna Maynard

(Residence in Baltimore: No. 2624 Stratford Ave St.; yrs., 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. W

5-If Married, Widowed or Divorced. (Write the word.) Married

6-DATE OF BIRTH. May 6 (Month) (Day) 1... (Year)

7-AGE. 29 yrs. 9 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Queenstown Md

PARENTS.

10-NAME OF FATHER. Wm A. Delahay

11-BIRTHPLACE OF FATHER, (State or Country). Talbot Co Md

12-MAIDEN NAME OF MOTHER. Roberta Howell

13-BIRTHPLACE OF MOTHER, (State or Country). Queenstown Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilbur Maynard

(Address) 2624 Stratford Ave

15- DEC 27 1922 Filed ..... 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 25 (Month) (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I viewed the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Influenza

Pneumonia over

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) H. C. Yates M. D.

(Coroner.)

1926 (Address) 1526 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence. Catonsville Md

19-PLACE OF BURIAL OR REMOVAL. Catonsville Md — DATE OF BURIAL. Dec 26 19...

20-UNDERTAKER. George Shuter — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70469

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70469

REGISTERED NO. 1129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 Cambridge ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Karel Dobry (Karel Dobry)

(a) RESIDENCE. No. 2120 Cambridge ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Dobry

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 72; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Joseph Dobry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Marie Dobry

(Address) 2129 Cambridge St

15 Filed DEC 27 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1922, to Dec 25, 1922

that I last saw h. alive on Dec 25, 1922,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Contributory)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) acute Nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Hunter, M. D.

Dec 26 1922 Address 1 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Dec 28 1922

20 UNDERTAKER: Frank Crockett — ADDRESS: 1406 Park Ave

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D70470

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70470

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 N Streeper ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carolina Ruzicka

(Residence in Baltimore: No. 530 N. Streeper St.; 50 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 80 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Joseph Zelenka

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Ant Kron

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Ruzicka

(Address) 530 N Streeper St

15- Filed DEC 27 1922, 191... ROBERT R. KNAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 26 (Day), 1922 (Year)

I HEREBY CERTIFY, That I attended deceased from Dec 24 1922, to Dec 26 1922, that I saw h[illegible] alive on Dec 26 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

La Gr Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William H. Doane M. D.

Dec 26, 1922 (Address) 530 N Streeper

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Hill

DATE OF BURIAL, Dec. 28, 1922

20-UNDERTAKER Ernest Brockman

ADDRESS 1906 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

D70471

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70471

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) U. T. I. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W. Leakin

(a) RESIDENCE NO. 103 W. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 24 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Sheppard W. Leakin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Isabella Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Miss Wilson

(Address): 103 W. Monument St

15 Filed ..., 19 DEC 27 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 26 19 22

17

I HEREBY CERTIFY, That I attended deceased from October 27, 19 22 to Dec 26, 19 22

that I last saw him alive on Dec. 26, 19 22

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of prostate, c Nephritis

(duration) 15 (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Streptococcus infection of wound (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? yes Date of Dec. 15, 1922

Was there an autopsy? no

What test confirmed diagnosis? Operation & Laboratory

(Signed) J. W. Finney Jr. M. D.

Dec 26, 1922. (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: 12-28-1922

20 UNDERTAKER: Geo. J. Jenkins & Sons Co

ADDRESS: Mt. Vernon Pl & Charles

Spec.—1-10-21—M&T—1500 Bks.

D70472

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70472

CERTIFICATE OF DEATH.

1100-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1552 Woodyear ST., 15 WARD)

2-FULL NAME Melvin Dimme

(a) RESIDENCE NO. 1552 Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item must be answered. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months: 8 | Days: 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Theo. Dimme

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Rachael Matt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Theo. Dimme 1552 Woodyear

15 DEC 27 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/23 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1922, to Dec. 23, 1922, that I last saw him alive on Dec 23, 1922, and that death occurred, on the date stated above, at 12.05 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia 10 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Capillary Bronchitis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Chas. A. Tomlinson, M. D.

12/27 19 (Address) 1019 Dimt Hilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Dec 27 1922

20 UNDERTAKER: Edward Ruggold

ADDRESS: 830 Cary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70473

CERTIFICATE OF DEATH.

49

D70473

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 3 WARD)

2-FULL NAME George Kavabos

(a) RESIDENCE NO. 12 S. Front St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pedler

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Greece

PARENTS

10 NAME OF FATHER: Steve Kavabos

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece

14 Informant (Address): Municipal Hospital Records.

15 Filed DEC 27 1922 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1922, to Dec. 24, 1922, that I last saw him alive on December 23, 1922, and that death occurred, on the date stated above, at 3:00 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung (duration) yrs. 8 mos None ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clyde McKeever, M. D.

12/27/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patricks Cemetery

DATE OF BURIAL: 12/27 1922

20 UNDERTAKER: Mrs N. S. Funk

ADDRESS 1737 W Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70474 HEALTH DEPARTMENT—CITY OF BALTIMORE D70474

CERTIFICATE OF DEATH.

X32

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (St.) 25 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy Scott

(a) RESIDENCE NO. Savage Md (ST., WARD)
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: N.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 24 yrs; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cotton Mill
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

0461

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Melvin Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " Do not know

14 Informant: Melvin Scott
(Address): Savage Md

15 DEC 27 1922 Filed, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-26 1922.

17 I HEREBY CERTIFY, That I attended deceased from 12-21, 1922, to 12-26, 1922, that I last saw him alive on 12-26, 1922, and that death occurred, on the date stated above, at 4 55 P m.

The CAUSE OF DEATH* was as follows:

Encephalitis

three weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) J. C. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Savage Md — DATE OF BURIAL: 12-27 1922

20 UNDERTAKER: E & B Hahn — ADDRESS: 115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70475

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70475

CERTIFICATE OF DEATH.

99-001

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1805 Maryland a ST.; 17 WARD)

2-FULL NAME Walter Lawrence L. Allen

(Residence in Baltimore: No. 1805 Maryland a St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	W Col.	Single

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE. ..... yrs. 8 mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... nw
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Walter Allen

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Rosie Blaine

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D Walter Allen

(Address) 1805 Mary

15- Filed DEC 27 1922, 191..... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Dec (Month) 26 (Day), 191 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) and that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Pneumonia .....

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs.....mos.....ds.

(Signed) ..... M. D.
(Coroner.)

Dec 26, 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park cemetery	Dec 27, 1922
-UNDERTAKER	ADDRESS
Edward W. Pye	903 Edmondson ave Catonsville Md

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70476 HEALTH DEPARTMENT—CITY OF BALTIMORE D70476

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3618 Sycamore Ave St.. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Wilson

(a) RESIDENCE. No. 3618 Sycamore Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or, WIFE of~~: Mary Emma Wilson

6 DATE OF BIRTH (month, day, and year): Oct 4-1834

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
88	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Machinist

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co Maryland

PARENTS

10 NAME OF FATHER: Samuel Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Amos

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs M. E. Wilson

(Address) 3618 Sycamore Ave

15 Filed DEC 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 26th 1922

17

I HEREBY CERTIFY, That I attended deceased from Jany 1 1917. to Dec 26th 1922. that I last saw h in alive on 24 of Dec. 1922. and that death occurred, on the date stated above, at 2 AM m.

The CAUSE OF DEATH* was as follows:

Diabetis Mel

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary test and symptoms

(Signed) M A Fair M. D.

Dec 26 1922 (Address) 12-E-25th st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Balto Co Md

DATE OF BURIAL: Dec 28 27 19

20 UNDERTAKER: A S Marshall

ADDRESS: 3539 Falls Road

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D70477

1-PLACE OF DEATH D70477 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 122 W. Montgomery ST., 22 WARD)

2-FULL NAME Baby Girl Blagmond

(a) RESIDENCE. No. 122 W Montgomery ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18, 1922

7 AGE Years Months Day: V If LESS than 1 day, 14 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER James Blagmond

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose Pilkey

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Hospital Records (Address)

15 Filed DEC 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk. (over)

19766

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1922, to Dec 21, 1922, that I last saw her alive on Dec 21, 1922, and that death occurred, on the date stated above, at 10:10 A m.

The CAUSE OF DEATH* was as follows:

Prematurity (36 Wks)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Marwood Wilson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

Per. Wm. F. Hubbert DEC 27 1922

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70478 HEALTH DEPARTMENT—CITY OF BALTIMORE D70478

CERTIFICATE OF DEATH. 181-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 514 N. Eutaw St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Wm. H. Ribbon

(Residence in Baltimore: No. 514 N. Eutaw St.; yrs., 4 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word): Married

6-DATE OF BIRTH: About (Month) (Day) 1877 (Year)

7-AGE: 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Printer
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Unknown.

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Norman

(Address) 514 N. Eutaw St

15-

FILED DEC 27 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 15, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by gas
from Stove

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) accidental

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Dec. 24 1922 (Address) 2 E Edmondson Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL. DATE OF BURIAL, 19

20-UNDERTAKER, Commissioner Health. ADDRESS DEC 2 1922

1926 MORGUE.

Ptr. Wm. S. WOODALL

Spec.—8-24-14—M. & T.—2000 Bks.

D70479

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70479

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 816 S. Chas St. St.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H Hackett

(Residence in Baltimore: No. 816 S. Chas Street St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Col	Married

6-DATE OF BIRTH, Aug 10, 1851
(Month) (Day) (Year)

7-AGE, 71 yrs. 4 mos. 14 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Cambridge Dorchester Co. Md.

PARENTS.

10-NAME OF FATHER, David Hackett

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estella Hackett

(Address) 816 S. Chas St.

15- DEC 27 1922 Filed....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 24, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 24 1922, to Dec 24 1922, that I saw h— alive on Dec 23 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis of Cerebral Hemorrhage

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Old Age

..... (Duration) ..... yrs. 7 mos. ..... ds.

(Signed) C. W. Fletcher M. D.

Dec 24 1922 (Address) 712 S. Chas St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cem	Dec 27, 1922
20-UNDERTAKER	ADDRESS
Jos. H. Case & Son	[illegible]

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70480

CERTIFICATE OF DEATH.

100-001

D70480

REGISTERED NO.

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE, No. ..... ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Flynn

(a) RESIDENCE No. 609 Fraser Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
83.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Bayview Hospital (Address) Baltimore, Md.

15 DEC 27 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1922 to Dec 22 1922

that I last saw her alive on Dec 22 1922

and that death occurred, on the date stated above, at 10-20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerotic Brain Disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) N. E. Goldsmith, M. D.

12/23 1922 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County

DATE OF BURIAL 12-27-1922

20 UNDERTAKER George J. Roth

ADDRESS 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70481

CERTIFICATE OF DEATH.

D70481

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1623 Clifton Place St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael McKenna

(Residence in Baltimore: No. 1623 Clifton Place St.; yrs., 60 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

6-DATE OF BIRTH. Aug (Month) 1 (Day) 1840 (Year)

7-AGE. 74 yrs. 4 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of Industry, business, or establishment in which employed (or employer) Police Officer 06

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, Owen McKenna

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Ellen [illegible]

13-BIRTHPLACE OF MOTHER, (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary McKenna (wife)

(Address) 1623 Clifton Place

15- Filed DEC 27 1922 ROBERT R. KRAUTER, Register.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, Dec (Month) 26 (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease,
(Heart) 1 mins. Instantaneous
for 1 yrs.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis
(Duration) 2 yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner)

12-26 192.2 (Address) 515 E. Fort Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Dec 29th 1922

20-UNDERTAKER, George J. Ruth

ADDRESS 1735 Harford Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D70482

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1328 W. North Ave ST., 13 WARD)

2-FULL NAME Wesley M. Owings

(a) RESIDENCE NO. 1328 W. North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, ~~or Divorced~~, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Owings

6 DATE OF BIRTH (month, day, and year) June 1st, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) (Retired)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mt Washington Md.

PARENTS

10 NAME OF FATHER Isreal Owings

11 BIRTHPLACE OF FATHER (city or town) Mt Washn. (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Burk

13 BIRTHPLACE OF MOTHER (city or town) Mt Washn. (State or country) Md

14 Informant Mrs Minnie E. Smith

(Address) 1328 W. North Ave.

15 DEC 27 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26th, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1922, to Dec 26, 1922, that I last saw h[illegible] alive on Dec 26, 1922, and that death occurred, on the date stated above, at 2 PM.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(duration) yrs. 1 mo. 26 ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible], M. D.

, 19 (Address) 1302 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Dec 28th 1922

20 UNDERTAKER T. Putnam Hose

ADDRESS 1753 W. Lafayette Ave

Spec.—1-10-21—M&T—1500 Bks.

D70483

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70483

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 N Rose ST., 6 WARD)

2-FULL NAME Norma Colligan

(a) RESIDENCE NO. 113 N Rose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Dec 4 - 1921

7 AGE: Years 1 | Months 1 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: None

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Jno M Colligan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wash DC

12 MAIDEN NAME OF MOTHER: Elizabeth Feldebrand

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Jno M Colligan

(Address) 113 N Rose St

15 Filed DEC 27 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 25 1922

17 I HEREBY CERTIFY, That I attended deceased from December 23 1922 to December 25 1922 that I last saw her alive on December 25 1922 and that death occurred, on the date stated above, at 6 30 P m

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert E Seuberg M. D.

19 (Address) 2027 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: Dec 28 1922

20 UNDERTAKER: John Merrick

ADDRESS: 200 E Preston

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery:* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"): *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70484

CERTIFICATE OF DEATH.

90 D70484

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 N Patterson Park Ave WARD)

2-FULL NAME Katherine Brill.

(a) RESIDENCE NO. 833 N Patterson Park Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of William Brill

6 DATE OF BIRTH (month, day, and year) Mar 2-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	9	23	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Henry Lauf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helen Reaburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Brill (Address) 833 N Patterson Park

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

DEC 27 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1922 to Dec 25 1922

that I last saw h alive on Dec 25 1922

and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) Wm. H. Welch M. D.

(Address) 1015 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Dec 28 1922

20 UNDERTAKER J Merritt

ADDRESS 25 E Preston

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70485

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

D70485

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3207 Dillon St ST., | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Sauer

(a) RESIDENCE NO. 3207 Dillon St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. . mos. . ds. How long in U. S., if of foreign birth? 70 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Sauer

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	10	1	

8 OCCUPATION OF DECEASED Retirad

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carl Sauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant George F. H. Sauer

(Address) 3207 Dillon St

Filed DEC 27 1922 19 ROBERT H. KNAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 22, 1922, to 12-25, 1922, that I last saw him alive on 12-25, 1922, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic nephritis.

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carl Schneider, M. D.

12/26, 1922 (Address) 2939 Eastender

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL Dec 28 1922

20 UNDERTAKER Zirkler + Zirkler — ADDRESS 1737 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Irene Turner ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70486

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70486

CERTIFICATE OF DEATH. 31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1155 Whatcoat ST. 16 WARD)

2-FULL NAME Irene Turner

(a) RESIDENCE. NO. 1155 Whatcoat ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 19-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Scholar

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jno. Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Neil Easton (Address) 926 Dallas Ave

15 DEC 27 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1922, to Dec 25, 1922.

that I last saw her alive on Dec. 26, 1922.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Maria E. Wagner M. D.

12/27/1922 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Dec 29 19
20 UNDERTAKER Neil Easton	ADDRESS 926

N. B.—WRITE PLAINLY, WITH LEAD PENCIL OR INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms; so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-00 D70487

D70487

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4009 Church St., 13 WARD)

2-FULL NAME Mary E Smith

(a) RESIDENCE NO. 4089 Church ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Smith

6 DATE OF BIRTH (month, day, and year) Oct 6 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or...min.
	87	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Serysville

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jos E Franton (Address) 4009 Church St

15 Filed DEC 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 21 1922 to Dec 26 1922.

that I last saw h alive on Dec 26 1922.

and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Prostatitis (Senile)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis?

(Signed) R L Norment M. D.

12 26 1922 (Address) 348 Chestnut St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Windsor Md — DATE OF BURIAL Dec 28 1922

20 UNDERTAKER Ehenowith Son — ADDRESS Chestnut St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70488

D70488

CERTIFICATE OF DEATH. 74-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 27 WARD)

2-FULL NAME Thomas F. Ford.

(a) RESIDENCE NO. 6. Washington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie E. Ford

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thos. Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Annie E. Ford
(Address) 2 Hadington Ave. Mt. Wash.

15 FILED DEC 27 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1922, to Dec. 27, 1922.

that I last saw him alive on Dec 27, 1922

and that death occurred, on the date stated above, at 10.35 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchial Pneu

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sym. & Signs

(Signed) J. J. [illegible], M. D.

, 19 (Address) J. Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Bulbco.	12/29. 1922
UNDERTAKER Thos. Ford.	ADDRESS 341 Saint

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10405 D7048

X 49 D70489

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) John Hopkins Hos. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. Pinto

(a) RESIDENCE NO. Princess Anne Md. Route 3 ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~Wife of~~: Cora A. Pinto

6 DATE OF BIRTH (month, day, and year): Apr 30, 1861

7 AGE — Years: 60 — Months: 7 — Days: 26 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John A. Pinto

11 BIRTHPLACE OF FATHER (city or town) (State or country): Portugal

12 MAIDEN NAME OF MOTHER: Deborah Woodcock

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: John Hopkins Hosp Records

(Address)

15 Filed DEC 27 1922 ROBERT. R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from December 11 1922 to Dec. 26 1922

that I last saw him alive on Dec. 26 1922

and that death occurred, on the date stated above, at 8 15 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of the head of the pancreas

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Dec. 20

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) J. H. Richert M. D.

(Address) John Hopkins Hospital

, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Princess anne Md

DATE OF BURIAL: Dec 27 19 2

20 UNDERTAKER: Joseph Ahrens

ADDRESS: 22 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70490

CERTIFICATE OF DEATH.

10 D70490

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victoria Kolota

(a) RESIDENCE. NO. 604 S. Port St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 28-1918

7 AGE: Years 4 Months 9 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balty. Md

PARENTS

10 NAME OF FATHER: Frank Kalota

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Amelia Razmystawicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Frank Kolota 604 S. Port St.

15 Date: DEC 27 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1922, to Dec. 27, 1922,

that I last saw her alive on Dec 27, 1922,

and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH was as follows:

Diphtheria, nasal tonsillar, pharyngeal & laryngeal

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) — yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? culture (+)

(Signed) B. Hagerman, M. D.

12/27/22, 19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Dec 27 1922

20 UNDERTAKER: John M. Weber — ADDRESS: 1803 Bank St

Spec.—1-10-21 M&T 1500 Blks.

D70491

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70491

CERTIFICATE OF DEATH.

118-002

1-PLACE OF DEATH Bay View Hosp - 3

CITY OF BALTIMORE: (No. Eastern Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia F Laherty

(a) RESIDENCE NO. 254 S Bond St WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Butler Laherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Whalen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Municipal Hosp. Records

(Address) " "

15 Filed DEC 27 1922, 19

Robert P. Harris.., Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26 " 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 24, 1922, to Dec 26, 1922, that I last saw h.e alive on Dec 26, 1922, and that death occurred, on the date stated above, at 4 45 P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction (high up):

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Evans Symptoms

(Signed) A Richardson Lynch M. D.

12-26, 1922 (Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents Cem

DATE OF BURIAL 12/29 1922

20 UNDERTAKER Chas P. Evans & Son

ADDRESS 11 S Wm St Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70492

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70492

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 4942 Park Heights Ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ross Euson

(a) RESIDENCE No. 4822 Denmore Av ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 15/1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Ruby Euson

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Bautz

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Ruby Euson (Address) 4942 Park Heights Ave

15 Filed DEC 27 1922, 19 Robert P. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26th, 1922, to Dec 26th, 1922

that I last saw him alive on Dec 26th, 1922

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Malignant Diphtheria

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) A. Lee Francis, M. D.

, 19 (Address) 1340 St Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 12/27 1922

20 UNDERTAKER Chas. H. Evans & Son — ADDRESS 118 East Royal Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70493

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70493

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4319 Ready Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane A. Bowerman

(a) RESIDENCE. No. 4319 Ready ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-20-1841

7 AGE — Years: 81 — Months: 6 — Days: 6 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Henry R. Bowerman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Bray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Wm H. Bowerman
(Address): 4319 Ready Ave

15 Filed DEC 27 1922, Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922, to Dec 26, 1922, that I last saw her alive on Dec 26, 1922, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Irregular Heart action

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. L. Duncan, M. D.

Dec 27, 1922 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: 12/28 19

20 UNDERTAKER: Wm Cook

ADDRESS: 552 Nor

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70494 D70494

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital REGISTERED NO. X155

CITY OF BALTIMORE: (No. Lombard & Greene St. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Warburton.

(a) RESIDENCE. No. 4030 Park Heights Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 4 ds. How long in U. S., If of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Warburton

6 DATE OF BIRTH (month, day, and year) March 8th 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34 years	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Civil Engineer (Mechanical ")

(b) General nature of industry, business, or establishment in which employed (or employer) D30

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Patterson N.J.

PARENTS

10 NAME OF FATHER Jas. Warburton

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Emma ? Clayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Hospital Records. (Address) University Hospital

DEC 27 1922

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-27 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-22, 1922, to 12-27, 1922 that I last saw him alive on 12-27 —, 1922 and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Bilateral Suppurative Frontal Sinusitis

(duration) yrs. 6 mos. weeks ds.

CONTRIBUTORY (Secondary) Septic Meningitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 12-22-22

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms.

(Signed) W. T. Jones, M. D.

12-27, 1922 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Dec 29 1922
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Gilmor St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70495

CERTIFICATE OF DEATH. 45

D70495

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 730 Hamburg St. ST., 21 WARD)

2-FULL NAME Anna Lawson

(a) RESIDENCE NO. 730 Hamburg St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 9" 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Joseph Lawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Lawson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Samuel Lawson

(Address) 1643 Wilkens Ave.

15 Filed DEC 27 1922 Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26" 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to Dec 26, 1922, that I last saw her alive on Dec 26, 1922, and that death occurred, on the date stated above, at 6.40 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

12/26 1922 (Address) 835 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Dec 28 1922

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bulls

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70496

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70496

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Baker ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Grasser

(a) RESIDENCE NO. 1621 Baker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Andrew Grasser

6 DATE OF BIRTH (month, day, and year) Feby 14 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	73	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Philip Lutz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Wicht

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Grasser

(Address) 1621 Baker st

15 Filed ....., 19.... Registrar

EC 27 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 1. , 1922, to Dec 27 , 1922,

that I last saw her alive on Dec. 26 , 1922,

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Asthma

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Herbert C Blake M. D.

12/27/1922 (Address) 1014 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Dec. 30 1922

20 UNDERTAKER Harry W. Ehlen — ADDRESS 1944 W. Mount

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70497

CERTIFICATE OF DEATH

D70497

74-001

REGISTERED NO.....

1-PLACE OF DEATH Bishop Road & University Parkway

CITY OF BALTIMORE: (No. Guilford Manor Apts ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella May Eisenhauer

(a) RESIDENCE. No. Guilford Manor Apts ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ (or) WIFE of George W. Eisenhauer

6 DATE OF BIRTH (month, day, and year) May 20 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Samuel F. Storey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary A. Booth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mr. Geo. A. Eisenhauer (Address) Guilford Manor Apts

15 Filed Dec 27 1922 Robert P. Garrison, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 24 1922 to Dec 25th 1922

that I last saw h. alive on Dec 25th 1922

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia of right side due to Cerebral Hemorrhage. 8 weeks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) Jefferies Buck M. D.

Dec 26 1922 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 12/28 1922

20 UNDERTAKER H E Hughes

ADDRESS 41st N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

D70498 HEALTH DEPARTMENT—CITY OF BALTIMORE D70498

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 807 Hayward Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Andrew Rise

(a) RESIDENCE, No. 807 Hayward Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 10 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 11-1883

7 AGE — Years: 39 — Months: 10 — Days: 14 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sign Decorator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Ferdinand Rise

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary V. Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Harry L. Rise

(Address): 2326 E. Madison St.

15 Filed ..... 19 ..... ROBERT R. KNAUER, Registrar

Burial Permit Clerk

DEC 28 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1922, to Dec 25, 1922.

that I last saw him alive on Dec. 25, 1922,

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 0 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? No Date of —

Was there an autopsy?

What tests were made that

(Signed) Robt F. Henderson, M. D.

, 19 (Address) Reisterstown Rd & Hayward

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec. 28 1922

UNDERTAKER: Horace F. Burgee — ADDRESS: 3631 Falls Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70499

CERTIFICATE OF DEATH.

90 D70499

REGISTERED NO.

D70499
1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 140 W. Lson ST. 14 WARD)

2-FULL NAME Anthony Bond Mc Elroy.

(a) RESIDENCE. NO. 140 W. Lson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Mc Elroy

6 DATE OF BIRTH (month, day, and year) March 10, 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	9	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER James Mc Elroy
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md
12 MAIDEN NAME OF MOTHER Mary Bond
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Elizabeth Mc Elroy
(Address) 140 W. Lson St

15 Filed DEC 28 1922, 19 ROBERT R. KNAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1922

17
I HEREBY CERTIFY, That I attended deceased from Aug. 1921, to Dec 27, 1922
that I last saw h[e] alive on Dec. 26, 1922
and that death occurred, on the date stated above, at 9.30 A m.
Dec 27-22
The CAUSE OF DEATH* was as follows:
Odema of Lungs

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) 2 yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) M. L. Lichtenberg, M. D.
12/27/1922 (Address) 2224 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral
DATE OF BURIAL DEC 29 1922
20 UNDERTAKER George J. Smith
ADDRESS 1852 Madison Ave

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

14-001

(PLACE OF DEATH) D70500 — REGISTERED NO. D70500

CITY OF BALTIMORE (No. 2829 N. Calvert St.) (17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gustav Herzer —

(Residence in Baltimore: No. 2829 N. Calvert St.: 50 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
M	W	Married

6 DATE OF BIRTH: Nov 5 (Month) (Day) 1872 (Year)

AGE: 50 yrs. 1 mos. 22 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Herman Herzer

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fredericka Herzer

(Address) 2829 N. Calvert St.

15 Filed ....., 191 — ROBERT R. KRAUTER, Burial Permit Clerk — REGISTRAR

DEC 28 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December 27 (Month) (Day) 1922 (Year)

17 I HEREBY CERTIFY, That I attended deceased from December 20, 1922 to December 27 1922

that I saw him alive on Dec 26 1922

and that death occurred, on the date stated above at 3a. m.

The CAUSE OF DEATH* was as follows:

Uremia - Sclerosis
Chronic Interstitial Nephritis
Unknown (Duration) yrs. mos. ds.

Contributory (SECONDARY) Cerebral Hemorrhage

(Duration) yrs. mos. 7 ds.

Signed Frederick L. Crum M. D.

Dec 27, 1922 (Address) 2827 N. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Baltimore County — DATE OF BURIAL: Dec 29, 1922

20 UNDERTAKER: George J. Smith — ADDRESS: Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D70501

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D70501

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1338 N. Calhoun ST., 15 WARD)

2-FULL NAME Ellen E. Suffman St

(a) RESIDENCE NO. 1338 N. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 6 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14- 1909

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
13	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER John Suffman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Della Speed

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) West Indies

14 Informant John Suffman
(Address) 1338 N. Calhoun

15 DEC 28 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.
6 1133

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-23- , 1922, to 12-27-22, 19 ,

that I last saw h[illegible] alive on 12-27-22, 19 ,

and that death occurred, on the date stated above, at 5 am m.

The CAUSE OF DEATH was as follows:

Acute Endocarditis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? "

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 624 N. Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	12-30 1922
20 UNDERTAKER John A. Soadwin	ADDRESS 142 Ostend St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history
Reported as Pulmonary
Tuberculosis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70502

CERTIFICATE OF DEATH.

90 D70502

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat ST. (WARD)

2-FULL NAME Charles H. Hooper

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 25, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mt Hope Retreat

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ann E. Brannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed , 19 ROBERT R. KRAUTER, Burial Permit Clerk. (Registrar)

DEC 28 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1922, to Dec 26th, 1922

that I last saw him alive on Dec 25, 1922,

and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

about

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart Sudden (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mt Hope Retreat

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

Dec 26. 1922 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	12/28 1922
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70503

CERTIFICATE OF DEATH.

47 D70503

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 Linden Ave. ST., 13 WARD)

2-FULL NAME Lina Katzenstein

(a) RESIDENCE NO. 2203 Linden Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Katzenstein.

6 DATE OF BIRTH (month, day, and year): July 6, 1877.

7 AGE — Years: 45 — Months: 5 — Days: 20 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Loeb Freudenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Johanna Hirsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Louis Katzenstein (Address) 2203 Linden Ave.

15 Filed ..... 19 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/26/1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1921, to Dec 26, 1922.

that I last saw h alive on Dec. 26, 1922.

and that death occurred, on the date stated above, at 7 15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

About (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Metastatic Carcinoma of Lungs (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 20, 1921

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore H. Morrison M. D.

, 19 (Address) 1528 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem. — DATE OF BURIAL: 12/29/1922

20 UNDERTAKER: David Sondheim — ADDRESS: 118 W. Mt. Royal Ave.

ROBERT R. KRAUTER

DEC 29 1922

Registrar

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70504

CERTIFICATE OF DEATH. X74-001 D70504

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

2-FULL NAME Nettie C. Foster

(a) RESIDENCE NO. 12 N. Washington St. Staunton Va ST., East WARD Staunton Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1860

7 AGE — Years: 62 — Months: 11 — Days: 22 — If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Private School.

(c) Name of employer: Stewart Hall Va.

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Robert Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Fannie Stribling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Johns Hopkins Hospital
(Address) Local

15 Filed DEC 28 1922 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21 1922, to Dec 28 1922, that I last saw her alive on Dec. 27 1922, and that death occurred, on the date stated above, at 8.25 a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 2 yrs. 2 mos 10 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Staunton Va

Did an operation precede death? Not Date of —

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Sara M Thompson M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Staunton Va. — DATE OF BURIAL: Dec. 31, 1922

20 UNDERTAKER: John C Mitchell — ADDRESS: Mount Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

D70505 HEALTH DEPARTMENT—CITY OF BALTIMORE D70505

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Childs Hosp St. 18 WARD)

2-FULL NAME Gertrude Donnelly.

(a) RESIDENCE NO. Nursery & Childs Hospital ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred City yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Donnelly

6 DATE OF BIRTH (month, day, and year) Oct. 16-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER John Donnelly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Pauline Murphy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilkes Barre Pa

14 Informant Pauline Murphy Wilkesbarre Pa
(Address) Wilkesbarre Pa

15 Filed DEC 28 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1922.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1922, to Dec. 26, 1922, that I last saw her alive on Dec. 26, 1922, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Indigestion

(duration) yrs. 1 mos 26 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. L. Grundy M. D.

, 19 (Address) 1002 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL 12-28th 1922

20 UNDERTAKER H. C. Branning Son

ADDRESS 517 N Schroeder St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70506

CERTIFICATE OF DEATH

109-002 D70506

REGISTERED NO.....

1-PLACE OF DEATH University Hospital ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Margaret Edwards

(a) RESIDENCE. NO. 5011 Augusta Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married.

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Frank W. Edwards

6 DATE OF BIRTH (month, day, and year) Dec 30-1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER — ? Wrightson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Husband & Mrs Edwards

(Address) 5011 Augusta Ave

15 Filed DEC 28 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26 1922.

17 I HEREBY CERTIFY, That I attended deceased from 12-26, 1922, to 12-26, 1922

that I last saw her alive on 12-26, 1922

and that death occurred, on the date stated above, at 605 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lingular

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Septicaemia - Brain Abscess

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? address above

Did an operation precede death? No Date of

Was there an autopsy? No. What test confirmed diagnosis? Clinical Findings

(Signed) Leon Weidow, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Dec 29 1922

20 UNDERTAKER — ADDRESS

Wm C Blacke — 927 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70507

CERTIFICATE OF DEATH.

100-001 D70507

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 651 Lee St. ST., 22 WARD)

2-FULL NAME Ellen Smith Thomas

(a) RESIDENCE NO. 651 W Lee ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Thomas

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE — Years: 56 — Months: — — Days: — — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work.

(b) General nature of industry, business, or establishment in which employed (or employer): Home duties

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Geo Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Margaret Carter
(Address) 112 Chase St.

15 Filed DEC 28 1922 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1922 to Dec. 25 1922,

that I last saw her alive on Dec 23 1922

and that death occurred, on the date stated above, at 8 30 p m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.
Hypostatic Congestion

(duration) yrs. mos 10 ds.

CONTRIBUTOR (Secondary): Acute Nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. L. Billinger M. D.

12/25 1922 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Dec 28 1922

20 UNDERTAKER: Mrs Robert A Elliott — ADDRESS: 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied: AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70508 D70508

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1308 N. Dallas ST., 8 WARD)

2-FULL NAME Rosealbah Jamison

(a) RESIDENCE NO. 1308 N. Dallas ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 19 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 8 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	1	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Robert A. Jamison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Maybelle Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mr Robert A. Jamison
(Address) 1308 N Dallas St

15 Filed DEC 28 1922 19 ..... ROBERT R. KRAUTER, Registrar
Central Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1 — 1922, to Dec. 27 1922, that I last saw her alive on Dec. 27 1922, and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos 21 dy.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test (confirmed diagnosis? .....

(Signed) J. E. Swinbeck, M. D.

(Address) 1521 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 29 1922
20 UNDERTAKER	ADDRESS
Henry Hoch Son	1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70509

100-001

D70509

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 N. Central Ave ST., 10 WARD)

2-FULL NAME Alphonsus P. Unkelbach

(a) RESIDENCE NO. 1121 N. Central Ave ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Sing'l.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 9 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Alphonsus J. Unkelbach

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sadie D. Fasano

13 BIRTHPLACE OF MOTHER (city or town) Boston, Mass.
(State or country)

14 Informant Mr Alphonsus J. Unkelbach
(Address) 1121 N. Central ave

15 Filed DEC 28 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1922, to Dec 27, 1922,

that I last saw him alive on Dec 27, 1922,

and that death occurred, on the date stated above, at 6 25 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John A. Fenby, M. D.

(Address) 8522 Greenmount ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Dec. 29 1922

20 UNDERTAKER Henry Horck Son — ADDRESS 1301 E. Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70510

CERTIFICATE OF DEATH.

101-009

D70510

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 S. Bethel ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ignatius Rohrs

(a) RESIDENCE. No. 208 S. Bethel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Rohrs

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John Jacobs

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER William Rohrs

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Josphine Risser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant (Address) Mollie Rohrs 208 S. Bethel st

15 Filed . 19 ROBERT R. KRAUSE Registrar

DEC 29 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-26 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 23rd, 1922, to Dec 26th, 1922, that I last saw h[illegible] alive on ....., 19 22, and that death occurred, on the date stated above, at 8-30 P m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Jacob L. Wharton, M. D.

12-27 1922 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12/30/22
20 UNDERTAKER	ADDRESS
Thos White 1135	Gilpin

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—5-19-13—M. & T.—500 Bks.

Doris M. Lattier

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 D70511

D70511 NUMBER OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1816 N Fulton Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris M Lattier

(Residence in Baltimore: No. 1816 N Fulton Ave St.; ...yrs., 4 mos. 19 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. August (Month) 8 (Day), 1922 (Year)

7-AGE. — yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John P Lattier

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Carrie M. Waterman

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John P. Lattier

(Address) 1816 N. Fulton Ave

15-

FILED DEC 28 1922 191.. ROBERT R. KNAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 27 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1922, to Dec 27 1922, that I saw h[illegible] alive on Dec 26 1922, and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH was as follows:

Otitis Cystitis

[illegible]

[illegible]

(Duration) ...yrs. ...mos. 5 ds.

CONTRIBUTORY (Secondary) Septicemia

(Duration) ...yrs. ...mos. 5 ds.

(Signed) Brian Edmunds M. D.

Dec 27 1922 (Address) 710 W Mt Royal Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL ~~OR REMOVAL~~. London Park

DATE OF BURIAL. Dec 29 1922

20-UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

Remarks No other history

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis*,	*Childbirth*,	*Convulsions*,
Hæmorrhage,	*Gastritis*,	*Erysipelas*,	*Meningitis*,
Gangrene,	*Miscarriage*,	*Necrosis*,	*Peritonitis*,
Phlebitis,	*Pyæmia*,	*Septicæmia*,	*Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70512

CERTIFICATE OF DEATH.

D70512

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 E. West Street. St., 24 90 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Henderson.

72 -- 6 --- 28.

(Residence in Baltimore: No. 117 E. West Street. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. May 28th, 1850.
(Month) (Day) (Year)

7-AGE. 72 yrs. 6 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. William P. Henderson.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Mary A. Mitchell.

13-BIRTHPLACE OF MOTHER, (State or Country). Snow Hill, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Edward Henderson. (brother)

(Address) 1637 E. North Ave.

15. DEC 28 1922 192

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 26th. 1922. 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) Otto K. Reinhardt M. D.
(Coroner.)

Dec. 27, 1922. (Address) 1017 E. Charles st.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park

DATE OF BURIAL. Dec 28 19

20-UNDERTAKER. John F. Denny

ADDRESS 715 Light St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70513

CERTIFICATE OF DEATH.

22 90

D70513

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 46 E. Montgomery St. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... William B. Norwood. 67 -- 1 -- 19.

(Residence in Baltimore: No. 46 E. Montgomery St. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. November 7th, 1855.
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
67 yrs. 1 mos. 19 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mill Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Belt Norwood.

11-BIRTHPLACE OF FATHER, (State or Country). Frederick Md.

12-MAIDEN NAME OF MOTHER. Isabelle ---- .

13-BIRTHPLACE OF MOTHER, (State or Country). Frederick Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Norwood. (wife).

(Address) 46 E. Montgomery St.

15. FILED DEC 28 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 26th, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto Reinhardt M. D.
(Coroner.)

Dec. 27, 1922. (Address) 1017 E. Charles st.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	Dec 29 1922
20-UNDERTAKER. John F Denny	ADDRESS. 715 Light St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70514

CERTIFICATE OF DEATH.

100-001

D70514

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 N. Duncan ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jonathan Spencer

(a) RESIDENCE NO. 507 N. Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 11/22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ...min.
	—	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Spencer

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Md

12 MAIDEN NAME OF MOTHER Elsie Nelson

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Elsie J. Spencer
(Address) 507 N. Duncan St

15 Filed DEC 28 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27/1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 26/1922, to Dec 27/1922,

that I last saw h... alive on Dec 26/1922,

and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam & Inspection

(Signed) S. H. Roder, M. D.

, 19 (Address) 1804 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Dec 29 1922.

20 UNDERTAKER Edward Bryson — ADDRESS 631 Orleans

Adam Taylor

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D70515

REGISTERED NO.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 743 Suzzrone ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant - Taylor, Adam -

(a) RESIDENCE. No. 743 Suzzrone ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 26, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Paul G. C. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bertha Kolasinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Paul G. C. Taylor
(Address) 743 S. Suzzrone St

15 Filed DEC 28 1922 ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28, 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1922, to Dec. 27, 1922, that I last saw him alive on Dec. 27th, 16 P.M., 1922, and that death occurred, on the date stated above, at 2. a. m.

The CAUSE OF DEATH* was as follows:

Congenital debility -
- Premature Birth -
Intestinal Hemorrhage (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of birth -

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm. M. Pannebaker, M. D.

, 19 (Address) 1209 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Dec 28 1922

20 UNDERTAKER	ADDRESS
John M. Weber	1803 Bank St

Charles W Rapp Sr

D70516 HEALTH DEPARTMENT—CITY OF BALTIMORE D70516

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH Car Barn at

City of BALTIMORE: (No. ~~19~~ Beech Columbia ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Charles W. Rapp Sr

(Residence in Baltimore: No. 3918 Woodbourne ave St.; yrs., 58 mos., 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word)
Mal.	white	Married

6-DATE OF BIRTH. Oct (Month) 21 (Day) 1864 (Year)

7-AGE. 58 yrs. 2 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Coach Painter
(b) General nature of industry, business, or establishment in which employed (or employer) U.M.E.R.R. Co

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER, John Rapp Jr

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Christina Eisemann

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Kate M. Rapp

(Address) 3918 Woodbourne ave

15 DEC 28 1922 Filed..... 192.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

DEC 28 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 26 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, aforesaid (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis with mitral valve stenosis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (Duration) Sudden yrs. mos. ds.

(Signed) James M. Kent M. D. (Coroner)

Dec 28 1922 (Address) 706 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
London Park	12/30/ 1922

20-UNDERTAKER. Chas. Weber & Son ADDRESS 2503 Edmondson ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

D70517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D70517

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1917 N. Caroline St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Edward S. Dorr

(Residence in Baltimore: No. 1917 N. Caroline St.; yrs. 47 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Jan 11 (Month) (Day) 1866 (Year)

7-AGE. 56 yrs. 10 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel

9-BIRTHPLACE, (State or Country). Union Bridge Md.

PARENTS.

10-NAME OF FATHER. John Dorr

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. M. Ford.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David S Dorr

(Address) 1917 N. Caroline St

15- Filed DEC 28 1922 192.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 26 (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy.

Shock of Fall and Contusion

2 yrs (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) J. S. H. Callan M. D. (Coroner.)

12-27 192.2 (Address) 508 E Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL. Mount Carmel Cemetery

DATE OF BURIAL. 12-29 192.2

20-UNDERTAKER. Geo. L. Ruth

ADDRESS 1735 Eastern Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70518

CERTIFICATE OF DEATH

86-001 D70518

REGISTERED NO.

1-PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard & Greene · ST.: 28 WARD)

2-FULL NAME Dennis B. Taylor.

(a) RESIDENCE. No. Woodside Road · The Hills ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred City yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Etta Kelly Taylor.

6 DATE OF BIRTH (month, day, and y) June 21, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secy & Treas. of Ditch Bowers & Taylor

(b) General nature of industry, business, or establishment in which employed (or employer) Storage Battery company

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John M. Taylor.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary R. Blondell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs. Etta Kelly Taylor. Woodside Road, The Hills

15 Filed DEC 28 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/27 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/26, 1922, to 12/27, 1922, that I last saw h~~im~~ alive on 12/27, 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute otitis Media

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Septic Meningitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Thos Riordon, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	12/30 1922
20 UNDERTAKER	ADDRESS
Henry W. Means & Son	805 N. Calvert St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Missing

#D 70519

Spec.—1-10-21—M&T—1500 Bks.

(Jahnigen)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70520

D70520

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 295 Schroeder ST., 18 WARD)

2-FULL NAME Howard Jahnigen

(a) RESIDENCE NO. 295 Schroeder ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. 10 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Febry 21-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	X	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm F. Jahnigen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Florence Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mr Wm F. Jahnigen

(Address) 295 Schroeder St

15 281922

Robert P. Harrison, 19.....

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 th 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 25th, 1922, to Dec 27, 1922,

that I last saw him alive on Dec 27, 1922,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Primary

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) P Wesley Hoag, M. D.

19 19 24 (Address) 724 Linden Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Dec 29th 1922.

20 UNDERTAKER John J. Cowan & Son

Per W.J. Cowan

ADDRESS 901 Hollins St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70521

CERTIFICATE OF DEATH.

45

D70521

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 7 S. Poppleton St ST., 18 WARD)

2-FULL NAME Jennie Kraft

(a) RESIDENCE NO. 7 S Poppleton St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

MARGIN RESERVED FOR BINDING

NOTICE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white.	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Michael Kraft

6 DATE OF BIRTH (month, day, and year) unknown 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Falls Md
(State or country)

PARENTS

10 NAME OF FATHER Matthew Greer

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mr Matthew Kraft
(Address) 844 N Carlton Ave

DEC 28 1922 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1922, to Dec 27, 1922

that I last saw h[illegible] alive on Dec. 27, 1922

and that death occurred, on the date stated above, at 4.45 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) ... yrs. ... mos, ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. Morley Hoag, M. D.

12/28 1922 (Address) 324 Franklin Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Dec 30 1922

20 UNDERTAKER John F. Cowan & Son, Geo H. J. Cowan

ADDRESS 908 Hollins St

D70522

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70522

CERTIFICATE OF DEATH.

161-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3822 Fait ave St. N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Naffel

(Residence in Baltimore: No. 3822 Fait ave St.; yrs. ..... mos. ..... ds.)

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Dec (Month) 24th (Day) 1922 (Year)

7-AGE: ..... yrs. ..... mos. ..... ds. If LESS than 1 day, One hour hrs. or ..... mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: Edward J. Naffel

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Bertha A Guckert

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwd J. Naffel

(Address) 3822 Fait Ave

15- Robert P. Harrison,

Filed ..... 192 ..... Registrar.

DEC 27 1922 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 24 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

about 5 months

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. R. Horton M. D. (Coroner.)

Dec 27 1922 (Address) Curtis Bay

*State the Disease Causing Death; or, in deaths from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. Balto

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State Md ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL, Dec. 28 1922

20-UNDERTAKER: Lilly & Zeile — ADDRESS 403 S Wolfe St

D70523

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70523

CERTIFICATE OF DEATH.

161-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3822 Fait ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Naffel

(Residence in Baltimore: No. 3822 Follit Ave St.; yrs....., mos....., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Dec. 24th (Month) (Day) 1922 (Year)

7-AGE: ..... yrs. One hour If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Edward J. Naffel

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Bertha A. Gucker

13-BIRTHPLACE OF MOTHER, (State or Country): Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward J. Naffel

(Address) 3822 Fait ave.

15. Filed 1922 Robert P. Garrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec. 24th (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained at said Inquest, Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth
about 5 months

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Hinton M. D. Coroner.

Dec 27th 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) Whether Accidental, Suicidal, or Homicidal.

Balto, Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem	Dec. 28 1922

20-UNDERTAKER,	ADDRESS,
Lilly & Zeile	403 S. Wolfe

Spec.—1-10-21—M&T—1500 Bks.

D70524

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70524

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1250 S. Shark ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Robert Stamp

(a) RESIDENCE No. 1250 S. Shark ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1922	Dec	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John R. Stamp

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Myers

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant John R. Stamp
(Address) 1250 S. Shark St

15 Dec 28 1922 Robert T. Griffith Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 27, 1922, to Dec 27, 1922, that I last saw h alive on Dec 27, 1922 and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
Several days

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. C. Dean M. D.

12-28-1922 (Address) 2800 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Dec 28 1922

20 UNDERTAKER Henry Lutz — ADDRESS 1203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

DEC 28 1922

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70525 D70525

CERTIFICATE OF DEATH.

38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

2-FULL NAME Dock Woods

(a) RESIDENCE NO. 208 Carlton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary's Co., Md.

PARENTS

10 NAME OF FATHER Dave Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records. (Address) JOHNS HOPKINS HOSPITAL

15 DEC 2 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 24 19 22

17

I HEREBY CERTIFY, That I attended deceased from December 13 19 22, to December 24 19 22.

that I last saw him alive on December 23, 19 22,

and that death occurred, on the date stated above, at 5:10 A.M.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(Cardiac)

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 4 mos ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clyde Means, M. D.

12/27/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health, ADDRESS

Wm. H. WOODALL DEC 2 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70526

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4032 St., Church 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Byron C. Holbrook

(a) RESIDENCE NO. 1413 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced (w) HUSBAND of (w) WIFE of: Sylvia Holbrook

6 DATE OF BIRTH (month, day, and year): Feb 8 1850

7 AGE: 72 Years 10 Months 19 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mercer Maine

PARENTS

10 NAME OF FATHER: Simeon Holbrook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Laura Williamson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mercer Me

14 Informant (Address): Bertha V. Cobb 4032 Church St

15 Filed DEC 28 1922, 19 Robert F. Harrison, Registrar

Dep. City Parcel Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12.27 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 26 1922 to Dec 27 1922

that I last saw h[illegible] alive on Dec 27 1922

and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) hours

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Henry E. Algire M. D.

12 27 1922 (Address) 2640 Woodland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys, Cem Hampden — DATE OF BURIAL: Dec 29 1922

20 UNDERTAKER: Walter R. McNamee — ADDRESS: 802 Wellington

A B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70527

D70527

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3008 Cedar Ave. ST., 13 WARD)

2-FULL NAME Ida D. Blaggett

(a) RESIDENCE No. 3008 Cedar Ave. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert E. Blaggett

6 DATE OF BIRTH (month, day, and year): July 27-1873

7 AGE: Years 49 Months 5 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Montgomery Co. Maryland

PARENTS

10 NAME OF FATHER: Josiah Hathaway

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mon. Co. Maryland

12 MAIDEN NAME OF MOTHER: Mary A. Beall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mon. Co. Maryland

14 Informant: Robert E. Blaggett

(Address): 3008 Cedar Ave.

15 Filed DEC 28 1922 19 Robert F. [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 27 1922

17

I HEREBY CERTIFY, That I attended deceased from May, 1922, to Dec 27, 1922

that I last saw her alive on Dec 27, 1922

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

b. Myocardial insufficiency

Uncertain (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) [signature] M. D.

Dec 28, 1922 (Address) 8429 Chatsworth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brownsville (Montgomery Co.) Md.

DATE OF BURIAL: Dec. 29, 22

20 UNDERTAKER: Horace H. Burgee

ADDRESS: 363 Falls Rd.

WARNING—RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70528

D70528

CERTIFICATE OF DEATH.

159-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 809 Winston Ave ST., 27 WARD)

2-FULL NAME Thelma Botzler

(a) RESIDENCE NO. 809 Winston Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 15 '22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Raymond Botzler

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary F. Kenly

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Raymond Botzler (Address) 809 Winston Ave

15 Robert P. Harrison, ... 19 ..... Registrar

Burial Permit Clerk.

DEC 28 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1922, to Dec 28, 1922,

that I last saw her alive on Dec 27, 1922

and that death occurred, on the date stated above, at 7 AM m.

The CAUSE OF DEATH* was as follows:

Debility

Foramen Oval not Closed

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. L. Fair, M. D.

, 19 (Address) 2. E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Presbyterian Govan;	Dec 29 1922
20 UNDERTAKER	ADDRESS
John M. Weber	1803 Bank St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70529 D70529

CERTIFICATE OF DEATH.

113

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 28 1922

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3413 Harford Ave WARD 8)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nelva F. Biegel

(a) RESIDENCE NO. 3413 Harford Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 27 1922

7 AGE: Years — Months 4 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Frank O Biegel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Sophia Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Frank O. Biegel

(Address): 3413 Harford Ave

15 Filed ..... 19 ..... Registrar

Robert P. Garrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1922, to Dec 27, 1922, that I last saw h[illegible] alive on Dec 27, 1922, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Indigestion, gastro intestinal cont. toxic; acidosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Indigestion gastro intestinal, tetany malnutrition (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Lyman Wittle M. D.

Dec 28 1922 (Address) 1227 N Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Dec 29 1922

20 UNDERTAKER: Jos Goerdens Son — ADDRESS: 207 S. Pen

Spec.—1-10-21—M&T—1500 Bks.

D70530

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70530

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2428 Liberty Heights Ave ST., 15 WARD)

2-FULL NAME Richard Wigley

(a) RESIDENCE NO. 2428 Liberty Heights Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma E. Wigley

6 DATE OF BIRTH (month, day, and year): Oct 21 1860

7 AGE — Years: 62 — Months: 2 — Days: 7 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edward Wigley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Harriet Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Emma E. Wigley

(Address) 2428 Liberty Heights Ave

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 28 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1920, to Dec 28, 1922

that I last saw him alive on Dec 28, 1922

and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Oo Lloyd, M. D.

, 19 (Address) 1132 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Dec 30 1922

20 UNDERTAKER: Wm J Fickus & Sons — ADDRESS: North & Pa

DEC 28 1922

WILL BE RETURNED TO PERSON GIVING INFORMATION

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70531 HEALTH DEPARTMENT—CITY OF BALTIMORE D70531

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH St. Agnes Hosp. REGISTERED NO.

CITY OF BALTIMORE: (NO. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David H. Murray

(a) RESIDENCE NO. 2709 Allen ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Murray

6 DATE OF BIRTH (month, day, and year) Feb 20 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46 yrs	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John R Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Jane Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Sarah Murray (Address) 2709 Allen Ave

15 Filed Oct 28 1922, 19 Robert F. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-27- 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-23- 1922, to 12-27- 1922

that I last saw him alive on 12-27- 1922

and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis - Myocarditis.

Cardiac Decompensation.

Chr. Nephritis -

Not Known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anuria - Cardiac Dilatation,

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W C Caldwell, M.D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge DATE OF BURIAL Dec 29 1922

20 UNDERTAKER Wm J Tickner Sons ADDRESS N Y Pa

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of ... or-mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D70532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D70532

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2706 Howard Place ST., 15 WARD)

2-FULL NAME Sarah Agnes Berat

(a) RESIDENCE No. 2706 Howard Pl ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 28 1922

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nephi Berat

6 DATE OF BIRTH (month, day, and year) May 22-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	64	1	4.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore Co (State or country) Md

PARENTS

10 NAME OF FATHER Lemuel Brown

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Emma Chaney

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Edw. F. Berat Jr

(Address) 2706 Howard Pl

15 Filed ..... 19 ..... Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1922, to Dec 26, 1922.

that I last saw her alive on Dec 25, 1922,

and that death occurred, on the date stated above, at 3. P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis of Chronic Myocarditis (duration) Unknown yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C.B. Emrich M. D.

12-28 1922 (Address) 5016 Park Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL Dec 29 1922

20 UNDERTAKER Wm. J. Rickert & Sons — ADDRESS Northern

Spec.—5-19-13—M. & T.—500 Bks (William Faust)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70533

D70533

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3904 Hawthorne ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Faust

(Residence in Baltimore: No. 3904 Hawthorne ave St.; 5 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widower

6-DATE OF BIRTH, Feb (Month) 10 (Day), 1843 (Year)

7-AGE, 79 yrs. 10 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, Danl Faust

11-BIRTHPLACE OF FATHER (State or Country), Penna.

12-MAIDEN NAME OF MOTHER Mary Spotts

13-BIRTHPLACE OF MOTHER (State or Country), Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Horace L Faust

(Address) 3904 Hawthorne Ave

15-

Filed ..... 191.....

Robert F. Harrison.

Burial Permit Clerk

Registrar.

DEC 26 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 27 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 19, 1922, to Dec 27 1922, that I saw him alive on Dec 27 1922, and that death occurred, on the date stated above, at 5 30 a m.

The CAUSE OF DEATH* was as follows:

.....

Mortuet Mitrale Regurgitation

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Edith Anderson M. D.

Dec 28 1922 (Address) 4896 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: London Park Cem — DATE OF BURIAL. Dec 29. 1922

20-UNDERTAKER Wm J Rickner Sons — ADDRESS North Ave

I.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D70534

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70534

CERTIFICATE OF DEATH.

88

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3908 Beaver ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Franklin Mason

(a) RESIDENCE NO. 3908 Beaver ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Mason

6 DATE OF BIRTH (month, day, and year) Nov 15 75

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 071

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer Garland & Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma Hulls

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Howard B Mason

(Address) 3908 Beaver ave

15 Filed DEC 28 1922, 19 Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/28 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Dec 28, 1922, that I last saw him alive on Dec 27, 1922, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Dementia with probably an enterocolitis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. G. Dewes, M. D.

, 19 (Address) 3501 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Dec 30 1922

20 UNDERTAKER W. Frank Jones

ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

G.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70535

CERTIFICATE OF DEATH.

90 D70535

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1219 Cloverdale Rd. ST.; 13 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Langdon

(Residence in Baltimore: No. 1219 Cloverdale Road. St.; 61 yrs., mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, Aug ? 1861
(Month) (Day) (Year)

7-AGE, 61 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Lady
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James Langdon

11-BIRTHPLACE OF FATHER (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER Mary Gaierty

13-BIRTHPLACE OF MOTHER (State or Country). Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Lynch

(Address) 219 W. Madison St

15-

Filed ..... 1922 Robert P. harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 20, 192.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Disease
Heart

(Duration) yrs. mos. d

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. d

(Signed) John Monahan M. D.
(Coroner.)

Dec 21, 192. (Address) 1432 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. d

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem

DATE OF BURIAL, Dec 23, 192.

20-UNDERTAKER Henry H. Parkinson

ADDRESS McCulloh cor Dolphin

DEC 28 1922

Spec.—1-10-21—M&T 1:00 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70536

CERTIFICATE OF DEATH (Montrose Park) 21

D70536

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) S.E. Parkwood + Highland Ave ST., (or) 35 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Popp

(a) RESIDENCE No. S.E. Cor Parkwood + Highland Aves ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Henry Popp

6 DATE OF BIRTH (month, day, and year) April 9, 1843

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
79	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Geo. Popp

(Address) S.E. Cor Parkwood + Highland Aves

DEC 28 1922

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1922 to Dec 27, 1922

that I last saw her alive on Dec 26, 1922,

and that death occurred, on the date stated above, at 1 45 P. m.

The CAUSE OF DEATH* was as follows:

Erysipelas (Facial)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Old Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W. Jones M.D.

, 19 (Address) 22 E. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Dec 29 1922

20 UNDERTAKER Jos Joerdens Son

ADDRESS 2175 Bway

Burial Permit

CB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Greenawald 1013 N. Charles st

Spec.—1-10-21—M&T—1500 Bks.

D70537

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70537

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1423 W. Fairmale ST., 16 WARD)

2-FULL NAME John T. Leitch

(a) RESIDENCE NO. 1423 W. Fairmale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M. Leitch

6 DATE OF BIRTH (month, day, and year) Jan 27-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baggage Master

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R R Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Leitch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elizabeth Leitch
(Address) 1423 W. Fairmale

15 Filed Dec 9 1922 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 24, 1922, to Dec. 26, 1922, that I last saw him alive on Dec 26, 1922, and that death occurred, on the date stated above, at 9:15 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos 26 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? X-Ray

(Signed) Paul F. Wilhat M.D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL Dec 9 1922

20 UNDERTAKER Lewis Cook — ADDRESS 5026 Harford

P.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

281922

D70538

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70538

CERTIFICATE OF DEATH.

Registered No. C 179

1-PLACE OF DEATH

City of BALTIMORE: (No. 1724 Frederick Ave St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles C. Thompson

(Residence in Baltimore: No. 1724 Frederick Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: January (Month) 29 (Day) 1918 (Year)

7-AGE: 4 yrs. 5 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: [illegible]
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country) Emmet Thompson

12-MAIDEN NAME OF MOTHER, Maryland

13-BIRTHPLACE OF MOTHER, (State or Country) Rida Sachse

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rida Thompson

(Address) 1724 Frederick Ave

15- Robert P. Harrison, 192

Burial Permit Clerk, Registrar.

DEC 28 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 28 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Scalds over trunk, perhaps body & legs 20 to 30 by pulling hot water accidentally

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. mos. 3 ds.

(Signed) James H. Preston M. D. (Coroner.)

Dec 28, 1922 (Address) 1011 Cathedral St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (I) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, Dec 30 1922

20-UNDERTAKER, William Cook — ADDRESS 502 E North Ave

WHITE, PLEASE, WITH CARBON PAPER—THIS IS A FUNERAL RECORD.

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70539 HEALTH DEPARTMENT—CITY OF BALTIMORE D70539

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 675 W. Mulberry (WARD) 4

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George D. Dudley

(a) RESIDENCE NO. 675 W. Mulberry (WARD) .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W Meth

5 If Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosalie Dudley

6 DATE OF BIRTH (month, day, and year): Sept 12 1859

7 AGE: Years 63; Months; Days; If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): Self.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland / Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Laura Lowenstein

(Address) 675 W Mulberry

15 Filed ....., 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk.

DEC 28 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 26 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1922, to Dec 26, 1922, that I last saw h.. alive on Dec 26, 1922, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary): Cardiac asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Anasarca

(Signed) Geo Bennett, M. D.

Dec 27 19 (Address) 202 E Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Wed 27 1922

20 UNDERTAKER: Wm Cook & Son — ADDRESS: 582 N Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70540

D70540

CERTIFICATE OF DEATH. 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 South 11th ST., No WARD)

2-FULL NAME William Sarod Crumbacker

(a) RESIDENCE NO. 3 South 11th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary B. Harris

6 DATE OF BIRTH (month, day, and year) Feb 27 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	65	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Geo Fuller Co.

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Jesse Crumbacker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Otta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Crumbacker

(Address) 3 So Eldredge Ct.

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 27th, 1922, to Dec 28, 1922,

that I last saw him alive on Dec. 27, 1922,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) acute Alcoholism

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank A. Gentz M. D.

Dec 28, 1922 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Dec 30 1922
20 UNDERTAKER	ADDRESS
H. M. Cole	602 E. Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 28 1922

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70541

CERTIFICATE OF DEATH.

129 D70541

REGISTERED NO. C.....

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Baltimore ST. ..... WARD) 3

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sol Kahn

(Residence in Baltimore: No. 1016 Granby St St.; 16 yrs. — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown ....., 1..... (Month) (Day) (Year)

7-AGE, 16 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Abraham Kahn

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Jennie Segovus

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Kahn

(Address) 1016 Granby St

15- Filed DEC 29 1922, 191... ROBERT R. KNAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 1922, to Dec 28 1922, that I saw h I M alive on Dec 28 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis c Uremia

..... (Duration) Not known

CONTRIBUTORY (Secondary)

2nd Anemia (Duration) ? yrs. ? mos. ? ds.

(Signed) Moses Seeman M. D.

Dec 28/22, 1922. (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Southern

DATE OF BURIAL, Dec 29 1922.

20-UNDERTAKER Max Levin

ADDRESS 1027 E Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70542

D70542

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 725 E. 20th. ST., 9 WARD)

2-FULL NAME Dollie Burk Bright.

(a) RESIDENCE NO. 725 E. 20th. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel B. Bright

6 DATE OF BIRTH (month, day, and year): June 14th 1876

7 AGE: Years 46; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Poultry Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer): Poultry

(c) Name of employer: Self. 045

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm R. Burk.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland.

12 MAIDEN NAME OF MOTHER: Margaret A. Stafford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Hannah Bright 725 E 20th St

15 Filed DEC 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Dec 25, 1922, that I last saw h alive on Dec 24 1922 and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? yes Date of Dec 1/21

Was there an autopsy? no

What test confirmed diagnosis? Pathological findings.

(Signed) Sherry Gay Ansley, M. D.

1922 (Address) 1800 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: 12/29/1922

20 UNDERTAKER: C. G. Moran

ADDRESS 300 E Baltimore

Spec.—1-10-21—M&T—1500 Bks.

Derr.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70543 8 D70543

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 N. Castle St ST., 8 WARD)

2-FULL NAME Clarence J. Derr

(a) RESIDENCE NO. 1917 N. Castle St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12/11/04

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			18	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Clarence W. Derr

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Amelia Murphy

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Clarence W. Derr
Address 1917 N. Castle St

15 DEC 29 1922 ROBERT R. KRAUTER, Filed ....., 19 ..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1922, to Dec. 30, 1922, that I last saw him alive on Dec 29, 1922, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

..... (duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jacob Frahm, M. D.

12/29 1922 (Address) 1823 N. Wash St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem. DATE OF BURIAL 1/3/1923

20 UNDERTAKER Geo J Ruth ADDRESS 1735 Hanfield Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70544

CERTIFICATE OF DEATH.

90

D70544

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 837 Raborg st St. 18 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Jarvis

(Residence in Baltimore: No. 837 Raborg st St.)

(If non-resident give STREET AND NUMBER OF INSTITUTION) ....yrs. ....mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col.

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1922 (Year)

7-AGE: 4 mos. ..... yrs. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: William Jarvis

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary Smith

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Pierce

(Address) 837 Raborg st

15- Filed DEC 29 1922 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 26 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the heart

(Duration) ....yrs. Don't know mos. ....ds.

CONTRIBUTORY (Secondary) Don't know

(Duration) ....yrs. 4 mos. ....ds.

(Signed) C. K. Gorsuch M. D. (Coroner.)

12-28 1922 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL: Dec 29 1922

20-UNDERTAKER: Brown's Eastland Belvedere — ADDRESS 114 ar

Spec.—8-24-14—M. & T.—2000 Bks.

D70545

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70545

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Fleet St ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosalia Jankowska

(Residence in Baltimore: No. 1707 Fleet St St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 37 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Jan Iwasec.

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Katherine Sobes.

13-BIRTHPLACE OF MOTHER (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Jankowski

(Address) 1707 Fleet St

15-

DEC 29 1922

16- ROBERT R. KRAUTER
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. 27, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 20 1922, to Dec 27 1922, that I saw h or alive on Dec 27 1922; and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:—

Sub acute Nephritis

.....

.....

..... (Duration) .....yrs. 1 mos. .....ds.

CONTRIBUTORY (Secondary) Uremic Convulsions

..... (Duration) .....yrs. .....mos. 3 ds.

(Signed) .....M. D.

Dec 29, 1922 (Address) 125 N Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Stanislaus Cem

DATE OF BURIAL, Dec. 29, 1922

20-UNDERTAKER Jacob Tiall Co

ADDRESS 428 S. Bond

85

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70546

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70546

CERTIFICATE OF DEATH.

118-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 Jefferson ST.; 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Filghman

(a) RESIDENCE. No. 1225 Jefferson st ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Albert Palant

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Irene Tisdale

(Address) 1225 Jefferson St

15 Filed DEC 29 1922, 19 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1922

17 I HEREBY CERTIFY. That I attended deceased from Dec 26, 1922, to Dec 27, 1922,

that I last saw her alive on Dec 27, 1922,

and that death occurred, on the date stated above, at 8:25 a m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion (Gastritis)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Probably Intestinal Obstruction

Volvulus (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Marcellus E. Foney, M. D.

, 19 (Address) 1445 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Dec 29 1922
20 UNDERTAKER	ADDRESS
Mrs Robert A Elliott	Oakland Md

A. B. WHITE PEARL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—3-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70547

CERTIFICATE OF DEATH.

129 D70547

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 N Centred Ave ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucretta Fields

(Residence in Baltimore: No. 611 N Centred Ave St.; ....yrs.,....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colord	Widow

6-DATE OF BIRTH, ..., 1..... (Month) (Day) (Year)

7-AGE, 70 yrs. mos. ds. | If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs R A Elliott

(Address) 1725-Ashland Ave

15-

Filed....., 191..... ROBERT R. KRAUTER, Registrar.

DEC 29 1922 Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY. That I attended deceased from Jan 10 1922, to Dec 27 1922, that I saw h[illegible] alive on Dec 27 1922, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Ephemeritis

(Duration) yrs. mos. 7 ds.

(Signed) C E Selby M. D.

Dec 27, 1922 (Address) 527 E Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laural Cemetery | DATE OF BURIAL, Dec 29 1922

20-UNDERTAKER Mrs R A Elliott | ADDRESS 1725 Ashland Ave

Special 1000 Bks. 500 Bks.

D70548

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70548

CERTIFICATE OF DEATH.

X 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 249 N. Bruce St ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Maddox

(a) RESIDENCE NO. 249 N. Bruce St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country) Sumner Co Tenn

PARENTS

10 NAME OF FATHER Samuel J Maddox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sumner Co Tenn

12 MAIDEN NAME OF MOTHER Rat-Wand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sumner Co Tenn

14 Informant Mary E Peary (Address) 1704 E Madison St

15 Filed DEC 29 1922 19 ROBERT N. KRAUSER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27, 1922

17

I HEREBY CERTIFY, That I attended deceased from December 26, 1922 to December 27, 1922 that I last saw him alive on December 26, 1922 and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr W Barnard M. D.

12-27 1922 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sumner Co Tenn	Dec 29 1922
20 UNDERTAKER Dyke Robert A Elliott	ADDRESS 1725 Ashland Av

N. B.—WHITE PERMIT, WHITE CERTIFICATE. THIS PERMIT AND CERTIFICATE BOTH MUST BE FILLED OUT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D70549 — CERTIFICATE OF DEATH — D70549

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No Kernan Hospital ST. 28 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Allen Lee Humphrey

(Residence in Baltimore: No. Sykesville Md St.: yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: September 10 (Month), 10 (Day), 1920 (Year)

7 AGE: 2 yrs. 3 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Sykesville Carroll Co Md

PARENTS

10 NAME OF FATHER: Benjamin Humphrey

11 BIRTHPLACE OF FATHER (State or country): Howard Co, Maryland

12 MAIDEN NAME OF MOTHER: Frank Fisher

13 BIRTHPLACE OF MOTHER (State or country): Carroll Co, Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Humbaugh

(Address) Sykesville, Md

15 DEC 29 1922

ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: December (Month) 29 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1922, to Dec 29 1922 that I saw him alive on Dec 28, 1922, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) ..... yrs. ..... mos. 20 ds

Contributory (SECONDARY) Generalized Tuberculosis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Wellington H Saunders M. D.

Dec 19, 1922 (Address) 1102 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. mos. 17 ds. In the State Life mos. ..... ds.

Where was disease contracted.

If not at place of death?

Former or usual residence Sykesville Md.

19 PLACE OF BURIAL OR REMOVAL: Sykesville Md — DATE OF BURIAL: Dec. 31 1922

20 UNDERTAKER: Geo. A. Necy — ADDRESS: Sykesville Md

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70550 D70550

CERTIFICATE OF DEATH.

11-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 Whittemore Ave. ST., 20 WARD)

2-FULL NAME Mary Sue Weddell

(a) RESIDENCE NO. 12 Whittemore Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Weddell

6 DATE OF BIRTH (month, day, and year) May 15" 1847

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
75	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac Co. Va.

PARENTS

10 NAME OF FATHER Joshua G. Wescott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Co. Va.

12 MAIDEN NAME OF MOTHER Margaret Pitts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Accomac Co. Va.

14 Informant W. Wharton Weddell

(Address) 13 Pine Heights Ave.

15 Filed DEC 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27" 19 22

17

I HEREBY CERTIFY, That I attended deceased from Dec 16. 19 22 to Dec 27. 19 22.

that I last saw her alive on Dec 27. 19 22.

and that death occurred, on the date stated above, at 11.40 A m.

The CAUSE OF DEATH* was as follows:

Grippe (probable)

(duration) yrs. 2 mos 21 ds.

CONTRIBUTORY (Secondary) Gastro Intestinal Catarrh

(duration) yrs. mos. 11 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) P. Gustav Diez M. D.

12/28/19 22 (Address) 145 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Dec. 30" 1922
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70551

CERTIFICATE OF DEATH.

D70551

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE—No. 5713 York Road ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline J Fleagle

(a) RESIDENCE NO. 5713 York Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed or divorced (or) WIFE of Howard L Fleagle

6 DATE OF BIRTH (month, day, and year) June 29 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	26	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore md
(State or country)

PARENTS

10 NAME OF FATHER Charles N. McGinnis

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Alice V. Hatton

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Howard L. Fleagle
(Address) 5713 York Road

15 Filed DEC 29 1922 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept - 1922 to Dec 27 1922

that I last saw her alive on Dec 27 1922

and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) W. L. Didusch, M. D.

, 19 (Address) 4916 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL Dec 30 1922

20 UNDERTAKER William Cook ADDRESS 502 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70552

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D70552

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 433 E. 22nd ST. 12 WARD)

2-FULL NAME John Royston Boblits

(a) RESIDENCE NO. 433 E. 22nd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Boblits

6 DATE OF BIRTH (month, day, and year) Dec 4. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penn R R

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md

PARENTS

10 NAME OF FATHER Michael Boblits

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Priscilla R. Royston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Emma B. Taylor (Address) 433 E 22nd St

15 Filed . 19 ROBERT R. KRAUTER, Registrar

DEC 29 1922

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. . 1921 . to Dec. . 1922. that I last saw him alive on Dec. 27th . 1922, and that death occurred, on the date stated above, at 1245 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I dont know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Asthma, Dropsy

(Signed) L. C. Schwatka M. D.

. 19 (Address) 822 W. North Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem't

DATE OF BURIAL Dec 31 1922

20 UNDERTAKER William Lock

ADDRESS 5026 Harford Ave

Spec.—1-10-21—M&T—1500 Bks.

160400
D70553

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D70553

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hos. ST., 7 WARD)

2-FULL NAME Mr. Isaac Bonine

(a) RESIDENCE NO. 527 Maine St. Niles, Michigan ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 9 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Alice Bonine

6 DATE OF BIRTH (month, day, and year) May 20 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER James Bonine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiania

12 MAIDEN NAME OF MOTHER Sarah Bogue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed DEC 29 1922 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1922, to Dec. 28, 1922

that I last saw him alive on Dec. 28, 1922

and that death occurred, on the date stated above, at 7 20 A.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis,

(duration) 5 yrs. + mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho pneumonia + pulmonary oedema (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Dec 23, 1922

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy.

(Signed) J. L. Houghton M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Via Buffalo Niles Michigan — DATE OF BURIAL Dec 29 1922

20 UNDERTAKER Chas. A. M. Walker — ADDRESS 73 W. Lafayette Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Hypertrophy
Operation for Prostate

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

99-001 D70554

D70554

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3904 Fernwood Ave. ST., 26 WARD)

2-FULL NAME Myron H. Merritt

(a) RESIDENCE NO. 3904 Fernwood Ave. ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 21 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	-	-	9.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER William M. Merritt

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine D. Brennan

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant William M. Merritt
(Address) 3904 Fernwood Ave.

15 Filed DEC 29 1922 19 ROBERT K. KNAUTH, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1922, to Dec. 28, 1922, that I last saw him alive on Dec. 28, 1922, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. D. Goldsmith, M. D.

, 19 (Address) 506 S. 3d Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Dec. 29 1922

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

D70555 (Byrne)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70555

CERTIFICATE OF DEATH.

Registered No. C. 179

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin St Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Elizabeth Byrne

(Residence in Baltimore: No. 1102 W Mulberry St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

6-DATE OF BIRTH. May (Month) 22 (Day) 1911 (Year)

7-AGE. 11 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School Girl
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Gold City

PARENTS.

10-NAME OF FATHER. Hugh J Byrne

11-BIRTHPLACE OF FATHER, (State or Country). England

12-MAIDEN NAME OF MOTHER. Catherine Clinton

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Byrne

(Address) 1102 W Mulberry St

15-

Filed DEC 29 1922 ROBERT R. KRAUTER Burial Permit Clerk Registrar. 192

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 27 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns over lower part of body & legs, accident

Total time during 2 hrs

(Duration) yrs. mos. 2 hrs. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. 6 mos. ds.

(Signed) James W Bunbar M. D. (Coroner.)

Dec 27 1922 (Address) 704 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

1102 W Mulberry St

Former or usual residence 1102 W Mulberry St

19-PLACE OF BURIAL OR REMOVAL. New Cathedral

DATE OF BURIAL. Dec 30 1922

20-UNDERTAKER. H. Browning Son

ADDRESS 517 N Schroeder St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70556

CERTIFICATE OF DEATH.

129 D70556

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 Light ST., 23 WARD)

2-FULL NAME Mary E. Scherer

(a) RESIDENCE NO. 1100 Light ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John Scherer

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 03/

PARENTS

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Isaac Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William J. Heckman

(Address) 1100 Light St

15 Filed DEC 29 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/10/22, 19 to 12/28/22, 19, that I last saw her alive on 12/28/22, 19, and that death occurred, on the date stated above, at 2 46 A m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation with edema of lungs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis & nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Brown, M. D.

19 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL Dec 30 1922

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

N.B. WRITE PLAINLY, WITH UNFADING INK. THIS STATEMENT IS RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70557 D70557

CERTIFICATE OF DEATH.

REGISTERED NO. 14431

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 E Hug ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula May Harbaugh

(a) RESIDENCE. No. 1909 E Hug ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Mulatto Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David W. Harbaugh

6 DATE OF BIRTH (month, day, and year) Feb 27 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Perry Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rosa Harmanson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant David W. Harbaugh (Address) 1909 E Hug St

15 Filed DEC 29 1922, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1922, to Dec 27, 1922, that I last saw h alive on Dec 26, 1922, and that death occurred, on the date stated above, at 1:26 A m.

The CAUSE OF DEATH* was as follows:

Ulcerative Endocarditis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Neurasthenia 4 years

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? no Date of no

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. S. McCard, M. D.

12/27, 1922 (Address) 2005 O'Donnell Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	12-29-22

20 UNDERTAKER George H. Holland ADDRESS 1631 Aisquith

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70558

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70558

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 930 E Monument ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christo Vlahos

(a) RESIDENCE No. 930 E. Monument ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 2 - 1922

7 AGE — Years | Months: 10 | Days: 28 | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Gus Vlahos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Georgie Vlanfas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Gus Vlahos

(Address) 930 E. Monument

15 Filed DEC 29 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1922, to Dec 28, 1922, that I last saw h— alive on Dec 28, 1922, and that death occurred, on the date stated above, at 9 1/2 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cholera of Infantum

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E E Mayer M. D.

(19 24 Address) 806 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Dec 30 19 22

20 UNDERTAKER: F. A. Krause & Son — ADDRESS: 703 Hanover

N. B. WHITE PAPER, WITH ORANGE INK, IS USED FOR THIS BLANK BECAUSE IT CAN BE EASILY DISTINGUISHED FROM OTHER PAPERS. Every question in this certificate should be carefully answered, with the information required. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70559

HEALTH DEPARTMENT—CITY OF BALTIMORE

185

D70559

CERTIFICATE OF DEATH.

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Deminer

(Residence in Baltimore: No. 3-31 Dolphin St Balt 64 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, Unknown (Month) (Day), 1858 (Year)

7-AGE, 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Lab.
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country), St Marys Co. Md

PARENTS.

10-NAME OF FATHER, Henry Deminer

11-BIRTHPLACE OF FATHER (State or Country), St Marys Co Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Daughter Emma Cain

(Address) 731 Dolphin St

15-

Filed DEC 29 1922, 191.. ROBERT R. KNAUER Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 26, (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primary Pneumonia Org. of Pulmon.
Contrib. Pulmon. Tuberculosis
accidentally contracted

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] (Coroner.) M. D.

Dec 29, 1922 (Address) 1639 Bradley

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, St Matthias Church

DATE OF BURIAL, December 31, 1922.

20-UNDERTAKER Jas Briers

ADDRESS 1725 Ashland Ave

Mrs Robert F Elliott

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bka.

D70560 HEALTH DEPARTMENT—CITY OF BALTIMORE D70560

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 217 E. Hamburg ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gentemann

(a) RESIDENCE. No. 217 E. Monteomery ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. / mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno F. Gentemann

6 DATE OF BIRTH (month, day, and year) July 18 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER August Gentemann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Jeanie Frazier.
(Address) 217 E. Hamburg St

15 Filed DEC 29 1922 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 25, 1922, to Dec 27, 1922, that I last saw h[illegible] alive on Dec 27, 1922, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Emrich, M. D.

12/28 1922 (Address) 610 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Dec 30 19 22
20 UNDERTAKER	ADDRESS
C. Schlosman & Son	Hanover St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70561

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70561

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 S. Sixth ST., 76 WARD)

2-FULL NAME Elizabeth Kafer

(a) RESIDENCE NO. 703 S. Sixth ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Kafer

6 DATE OF BIRTH (month, day, and year): June 26-1847

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
75	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Adam Henlein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant (Address): Adam Kafer 703 S. Sixth St.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk.

DEC 29 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 25, 1922, to Dec 27, 1922, that I last saw her alive on Dec 27, 1922, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis
+ myocarditis
(duration) ... yrs. 2 mos ... ds. contrib

CONTRIBUTORY (Secondary): Dilated heart
(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm M. Mc Avoy, M. D.

12/27, 1922 (Address) 139 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn Cemetery — DATE OF BURIAL: Dec. 30 1922

20 UNDERTAKER: Zirkler + Zirkler — ADDRESS: 1739 E. Eager St

N. B.—WHITE PENCIL, WHEN CAPITALS ARE USED FOR INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70562

CERTIFICATE OF DEATH.

90 D70562

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 803 S Potomac St., 1 WARD)

2-FULL NAME Jacob Baranowski

(a) RESIDENCE NO. St. Joseph's Hosp. ST., 1 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874 July 25

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Stella Baranowski 803 S Potomac St

15 Filed .19 Registrar Burial Permit Cleared

DEC 29 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27, 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1922 to Dec 27, 1922, that I last saw him alive on Dec. 26, 1922 and that death occurred, on the date stated above, at 3201 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Kruger, M. D.

.19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem — DATE OF BURIAL Dec 30 1922

20 UNDERTAKER Stephen F Fialkowski — ADDRESS Wood Kenwood Av

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70563

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70563

HEALTH DEPARTMENT—CITY OF BALTIMORE

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2410 Fait Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Subik

(a) RESIDENCE. No. 2410 Fait Ave ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? 23 yrs — mos — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 25-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41 -	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wajk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

11 Informant Gina Subik
(Address) 2410 Fait Ave

12 Date DEC 20 1922 ROBERT P. HARRISON, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov. 10 19 22, to Dec 27 19 22

that I last saw her alive on Dec 26 19 22

and that death occurred, on the date stated above, at 4-30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovaries
(from history)

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) exhaustion.

(duration) yrs. — mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of about Aug 1 HH

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) Duncan Conrad M. D.

, 19 (Address) 811 N. Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Dec 30 1922
20 UNDERTAKER	ADDRESS
Thos F Kealy	[illegible]

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70564 HEALTH DEPARTMENT—CITY OF BALTIMORE D70564

CERTIFICATE OF DEATH. 162

REGISTERED NO.....

1-PLACE OF DEATH Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gibson

(a) RESIDENCE NO. Johns Hopkins Hospital ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec - 16 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Johns Hopkins Hospital.
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Calvin H. Gibson

11 BIRTHPLACE OF FATHER (city or town) Tolchmeis Island
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Kathleen Heard.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant W.W. Gray
(Address) Johns Hopkins Hospital.

15 Filed ..... 19 ..... Registrar Robert T. Harrison, Burial Permit Clerk.

DEC 29 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec - 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 192 , to Dec 17, 192 ,

that I last saw him alive on Dec 17, 1922,

and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes. Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) W.W. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL DEC 29 1922 19

20 UNDERTAKER Commissioner Health.

ADDRESS .....

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70565

CERTIFICATE OF DEATH.

74-001

D70565

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3142 Fredk. Ave ST. 70 WARD)

2-FULL NAME Mary M. Tribbe

(a) RESIDENCE NO. 3142 Fredk. Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William H. Tribbe

6 DATE OF BIRTH (month, day, and year): Oct. 25 1855.

7 AGE: 67 Years 2 Months 2 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Michael Burmeister

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Cath. Meier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Thos. H. Tribbe

(Address) 3142 Fredk. Ave

15 Filed ..., 19 ... Registrar

Robert P. Garrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1921, to Dec 27 1922, that I last saw h~~e~~ alive on Dec 26 1922, and that death occurred, on the date stated above, at 330 A. M.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Apoplexy)

Arterio Sclerosis

Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Barbara C. Tyler M. D.

12/29 1922 (Address) 2151 Walbrook ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 12-30 1922

20 UNDERTAKER: C. W. Dick — ADDRESS: 3109 Fredk Ave

C 29 1922

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D70566

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70566

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 707 N. Eden ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Cummings

(Residence in Baltimore: No. 707 N. Eden street St.; .....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ... (Month) July (Day) 27, (Year) 1859

7-AGE, 63 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook
(b) General nature of Industry, business, or establishment in which employed (or employer)..... Private

9-BIRTHPLACE, (State or Country), Balto, Md

PARENTS.

10-NAME OF FATHER, Jas. H. Cummings

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER .....

13-BIRTHPLACE OF MOTHER (State or Country). .....

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Robert P. Harrison

(Address) 707 N. Eden

15- DEC 29 1922

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Dec (Day) 26, (Year) 1922

17- I HEREBY CERTIFY, That I attended deceased from Dec 21 1922, to Dec 26 1922, that I saw h[illegible] alive on Dec 26, 1922, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) .....yrs. 15 days mos. .....ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

..... (Duration) /.....yrs. .....mos. .....ds.

(Signed) R. P. Smith M. D.

Dec 28, 1922 (Address) 2400 Division St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Asbury Evergreen Cemetery

DATE OF BURIAL, Dec 28, 1922

20-UNDERTAKER Chas J. Bailey

ADDRESS 1921 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70567

CERTIFICATE OF DEATH.

90 D70567

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 607 Brune St. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Julia Harrison

(a) RESIDENCE NO. 607 Brune St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia Peacock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. W. L. Weihrauch

(Address) 74 Miller Ave. Catonsville

15 Filed 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28th 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1922, to Dec 28, 1922, that I last saw her alive on Dec 28, 1922 and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis ?
Myocarditis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. S. Tyler Thomas M. D.

12/28/22 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Dec 30 1922

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N. Gilmor St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

29 1922

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70568

CERTIFICATE OF DEATH.

129 D70568

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emmanuel Fried

(Residence in Baltimore: No. Old Folks Home - Hebrew Hospital St.; ..... yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, March 14, 1845 (Month) (Day) (Year)

7-AGE, 77 yrs. 9 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired - 45
(b) General nature of industry, business, or establishment in which employed (or employer): Shoe business

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Louis Fried

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Bluemchen Hirzberg

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Marian Rothschild

(Address) 2317 Eutaw Place

15- Robert P. Harrison,

Filed ....., 191.....

C 291922 Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 28 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 25 1922, to Dec 28 1922, that I saw him alive on Dec 28 1922, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uraemia

(Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Moses Gellman M. D.

Dec. 28, 1922 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 3 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? not known

Former or usual residence Hebrew Home

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship

DATE OF BURIAL, 12-31, 1922

20-UNDERTAKER Howard Sandheimer

ADDRESS 115 W. Mt Royal Ave

D70569

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70569

Harriet Lane.

CERTIFICATE OF DEATH.

71-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie Betty Croxton

(Residence in Baltimore: No. 20 E. 21 St.; yrs.. ..mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	

6-DATE OF BIRTH, Oct (Month) 10 (Day) 1912 (Year)

7-AGE, 10 yrs. 2 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Richard H Croxton

11-BIRTHPLACE OF FATHER, (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER, Clara L Robinson

13-BIRTHPLACE OF MOTHER, (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard H Croxton

(Address) 26 E. 21 St

15- Filed ..... 192.....

Robert P. Harrison, Burial Permit Clerk. Registrar.

DEC 29 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 29 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) 1 mos.

CONTRIBUTORY (Secondary) Acute Meningitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Cullino Bladel M. D.

Dec 29 1922 (Coroner.) (Address) 143 N Broadway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Westminster — DATE OF BURIAL, Dec 31 1922

20-UNDERTAKER W C Tuckerman — ADDRESS Walbrook

Every item of information called for should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

H D70570

HEALTH DEPARTMENT—CITY OF BALTIMORE

10 D70570

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2110 N. Charles ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Mary Roberts

(Residence in Baltimore: No. 2110 N. Charles St.; 2 yrs., 5 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Child

6-DATE OF BIRTH, July (Month) 15 (Day), 1920. (Year)

7-AGE, 2 yrs. 5 mos. 13 ds.

If LESS than 1 day, ..hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph J. Roberts

11-BIRTHPLACE OF FATHER (State or Country), Connecticut

12-MAIDEN NAME OF MOTHER May B. Clarke

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. J. Roberts MD

(Address) 2110 N. Charles St.

15- Dec 29, 1922

Robert P. Harrison, Burial Permit Clerk. Registrar.

C 291322

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, December (Month) 28 (Day), 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1922, to Dec 28 1922, that I saw her alive on Dec 28 1922, and that death occurred, on the date stated above, at 10 15 m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Septic bronchitis

(Duration) ... yrs. ... mos. 5 ds.

(Signed) Bronson Pitt M. D.

Dec 28, 1922 (Address) 2435 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, Dec 24, 1922

20-UNDERTAKER Geo W. Friedel Son

ADDRESS 811 N Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70571

CERTIFICATE OF DEATH. 65-002

D70571

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 S. 4th St. ST.: 26 WARD)

2-FULL NAME Henry Feldman

(a) RESIDENCE. No. 810 S. 4th St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. 7 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Feldman

6 DATE OF BIRTH (month, day, and year) May 7-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer) 0&6

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER August Feldman

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Wm Rochner (Address) 810 S 4th St

15 Filed ..... 19..... Registrar

Robert P. Garrison, Burial Permit Clerk.

30 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to Dec 27, 1922.

that I last saw h~~e~~ alive on Dec 27, 1922.

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Hodgkins disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. Edw. Smith, M. D.

19 22 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Dec 30 19 22
20 UNDERTAKER	ADDRESS
Edw Lindenbach & Son	647 W Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70572

D70572

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1252 Riverside Ave. ST., 23 WARD)

2-FULL NAME August H. Dougherty. Jr.

(a) RESIDENCE NO. 1252 Riverside Ave. ST., 23. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6, 1921.

7 AGE	Years	Months	Days	If less than 1 day, hrs. or min.
		9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER August H. Dougherty.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Freund.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant August H. Dougherty
(Address) 1252 Riverside Ave.

15 Filed ....., 19 ..... Registrar

C 301922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1922, to Dec. 28, 1922, that I last saw him alive on Dec. 28, 1922, and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 2½ ds.

CONTRIBUTORY (Secondary) over

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Theodore Ewalt M. D.

12/29 1922 (Address) 905 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Dec 30, 1922

20 UNDERTAKER Mrs J. E Evans & Sons # ADDRESS 1428 S Charles St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Coroner 1101 N. Fulton

D70573

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70573

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1831 Riggs ave ST., 16 WARD)

2-FULL NAME Emelie Louise Suman

(a) RESIDENCE NO. 1831 Riggs ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Suman

6 DATE OF BIRTH (month, day, and year) Sept 5 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	67	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) North Point
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas H. Evans

11 BIRTHPLACE OF FATHER (city or town) North Point
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emelie Howell

13 BIRTHPLACE OF MOTHER (city or town) North Point
(State or country) Maryland

14 Informant Henry L. Suman
(Address) 1831 Riggs ave

15 Filed ..... 19 ..... Registrar

C 30 01922 David Ferwit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 28 1922 to Dec 28 1922

that I last saw h[illegible] alive on Dec. 28 1922

and that death occurred, on the date stated above, at 845 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

3 hours
(duration) ... yrs. mos ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. C. Conser M. D.

12/29/1922 (Address) 1101 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 1/1/23 19

20 UNDERTAKER Geo. Weber & Son 2503 Edmondson — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D70574

D70574

CERTIFICATE OF DEATH.

X 74-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

2-FULL NAME Mrs Sophia B. Buxton

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Buxton

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	74	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Montgomery Co (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Reid

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York State

12 MAIDEN NAME OF MOTHER Sophia Peckham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md

15 Filed Dec. 6, 1922 Nellie Lee Allison Registrar

Burial Permit Clerk.

C 30 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1922, to Dec 4, 1922, that I last saw h 22 alive on Dec 4, 1922, and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia - Post Cerebral Embolism

abt (duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Dementia Paralytica -

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? Gaithersburg Md.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crypt Rus - Mt Hope	Dec. 6 1922
20 UNDERTAKER Chas. E. Gaehwiler	ADDRESS Gaithersburg

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70575

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D70575

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 McMechen ST., 14 WARD)

2-FULL NAME Anna E Shaffer

(a) RESIDENCE No. 125 McMechen ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas O Shaffer

6 DATE OF BIRTH (month, day, and year) April 6 22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Greencastle (State or country) Pa.

PARENTS

10 NAME OF FATHER Alfred Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER L E Warner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Thomas O Shaffer (Address) 125 N McMechen St

15 Filed ....., 19.....

Robert F. [illegible] Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec-28-1922

17 I HEREBY CERTIFY, That I attended deceased from Sept- , 1919 , to Dec-28- , 1922 ,

that I last saw her alive on Dec-26- , 1922 ,

and that death occurred, on the date stated above, at 8.45a m.

The CAUSE OF DEATH* was as follows:

Aortic and mitral regurgitation

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs and symptoms.

(Signed) L. H. Fargo, M. D.

, 19 (Address) Walbert Apts. 1900 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Dec 30 1922

20 UNDERTAKER H. M. Ronson

ADDRESS 2238 N Howard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

30 1922

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70576 ✓ D70576

CERTIFICATE OF DEATH.

X 129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.) (WARD)

2-FULL NAME Mrs. Margaret L. Roberts

(a) RESIDENCE. No..... Owings Mills, Md. ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Length of time in U. S. ... How long in this locality yrs. mos. ds. (If nonresident give city or town and State) Hospital

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse Wisner Roberts.

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone operator

(b) General nature of industry, business, or establishment in which employed (or employer) " " 86

(c) Name of employer Rosewood State School

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Augustus Shinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Haines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland Hospital Records

14 Informant (Address)

15 Filed . 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30, 1922.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1922, to Dec. 30, 1922.

that I last saw h e r alive on Dec. 30, 1922

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Arterial Hypertension

Chronic Diffuse Nephritis

(duration) unknown

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination + Laboratory Tests

(Signed) R. L. Jones, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmitsburg Md	Jan 1 1922

20 UNDERTAKER W M Rontson

ADDRESS 2235 N North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—3-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D70577

D70577

CERTIFICATE OF DEATH.

11-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 Bentalou ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John King

(Residence in Baltimore: No. 527 Bentalou St.; 11 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, ... (Month) 1877 (Year) ..... (Day) 1 .....

7-AGE. 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Farming

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Fulton

(Address) 527 Bentalou

15-

Filed ....., 191.. Robert P. Harrigan, Registrar.

DEC 30 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Dec. (Day) 27 (Year) 1922.

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22 1922, to Dec. 27th 1922, that I saw h.. alive on Dec. 26th 1922, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows: Broncho Pneumonia

..... (Duration) ..... yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Grippe Influenza

..... (Duration) 3 yrs. ..... mos. 7 ds.

(Signed) A. Lee Ellis M. D.

1417 ....., 191.. (Address) 72 Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Dec 30, 1922

20-UNDERTAKER Daniel Easter ADDRESS 926 Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70578

HEALTH DEPARTMENT—CITY OF BALTIMORE

52

D70578

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 Rossiter ave ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Earnest Geist

(a) RESIDENCE. NO 520 Rossiter ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Estelle Geist

6 DATE OF BIRTH (month, day, and year) July 3 1888.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

062

9 BIRTHPLACE (city or town) (State or country) Baltimore County. Md.

PARENTS

10 NAME OF FATHER Jacob K. Geist

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md

12 MAIDEN NAME OF MOTHER Mary R. Crommer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md.

14 Informant Mary E. Geist

(Address) 520 Rossiter ave.

15 Filed DEC 30 1922 19 Registrar Robert P. Harrison, Jr. Assistant Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 1922.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1922, to Dec. 29, 1922, that I last saw him alive on Dec. 28, 1922, and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynicane

(Signed) H C Reed, M. D.

12.29 1922 (Address) 6600 York Rd. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wesleyan Chapel Harford Co Md

DATE OF BURIAL: Dec 31 1922

20 UNDERTAKER: Geo Entwisle

ADDRESS: 120 W Lafayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 30 1922

Spec.—8-24-14—M. & T.—2000 Bks.

D70579

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70579

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Mc Elderry St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Armstrong

(Residence in Baltimore: No. 1305 Mc Elderry St.; ....yrs., ...mos. ....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, Dec (Month) 27 (Day), 1922 (Year)

7-AGE, 53 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer) U.S.

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Edna Lorest

(Address) 1302 Jefferson St

15-

Filed ....., 191.....

Robert F. Garrison, Registrar.

Registrar's Permit Clerk.

301922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 27 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 18 1922, to Dec 27 1922, that I saw him alive on Dec 26 1922, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ....yrs. ....mos. ....ds.

(Signed) Ralph T Young M. D.

12/30, 1922 (Address) 1424 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ever Green Cem. DATE OF BURIAL. Dec 31, 1922

20-UNDERTAKER Mrs J. Y. Locke ADDRESS 1302 Jefferson

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70580

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70580

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2013 W. Baltimore ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Copenspire

(a) RESIDENCE. NO. 2013 W. Baltimore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Cavera

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Flora Woodward
(Address) 2013 W. Baltimore St

15 Filed ..., 19.. Registrar

C 3 0 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1922, to Mar 28, 1922

that I last saw h alive on Mar 25, 1922

and that death occurred, on the date stated above, at 1410 m.

The CAUSE OF DEATH* was as follows:

I

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cholecystitis

(duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly M. D.

3/29/1922 (Address) 1027 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: Mar 30 19

20 UNDERTAKER: Geo. J. Smith

ADDRESS: 1033 Hollins

BURIAL PERMIT ISSUED

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70581 HEALTH DEPARTMENT—CITY OF BALTIMORE D70581

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital or on way to from Extend Murray St. 22 Ward)

2-FULL NAME Thomas L Davis

(Residence in Baltimore: No. 102 E Montgomery St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

6-DATE OF BIRTH, ... (Month) (Day) 1857 (Year)

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ship Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Ship

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Wm J Davis

11-BIRTHPLACE OF FATHER, (State or Country): Taylor Island Md

12-MAIDEN NAME OF MOTHER: Sarah Cook

13-BIRTHPLACE OF MOTHER, (State or Country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Elizabeth Davis (Sister)

(Address) 102 E Montgomery St

15-

Filed ..... 192.....

Robert P. Garrison
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 27 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull
accidentally struck by auto
few minutes (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

Dec 30 1922 (Address) .....

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Dec 30 1922

20-UNDERTAKER: John F Denny — ADDRESS: 715 Light St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 30 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70582

CERTIFICATE OF DEATH.

129

D70582

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3005 Erdman ST., 8 WARD)

2-FULL NAME Thomas J Reilly

(a) RESIDENCE NO. 3005 Erdman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Reilly

6 DATE OF BIRTH (month, day, and year) Sept 14 1826

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	96	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 046

(b) General nature of industry, business, or establishment in which employed (or employer) Rolling Mill Worker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Chas. Reilly

(Address) 3005 Erdman

15 Filed , 19 Registrar

30 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1922, to Dec. 28, 1922, that I last saw him alive on Dec 27, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. F. Stevens, M. D.

12/29/1922 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem.

DATE OF BURIAL 12/30/22 19

20 UNDERTAKER George J. Pettit

ADDRESS 1128 Hartford

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70583 45 D70583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 826 Fessier ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Gardener

(Residence in Baltimore: No. 826 Fessier St. St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, September 1855
(Month) (Day) (Year)

7-AGE, 67 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 041

9-BIRTHPLACE, (State or Country), Elkridge Md

PARENTS.

10-NAME OF FATHER, Thos B Cole

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah Helen

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw Shaw

(Address) 826 Fessier St

15-

Robert P. Harrison,

Filed ....., 191.....

Registrar.

DEC 30 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 27, 1922
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 27 1922 to Dec 27 1922 that I saw h[illegible] alive on Dec 27 1922, and that death occurred, on the date stated above, at 9 33 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Carcinoma

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

(Signed) John E Stewart M. D.

12-30 1922 (Address) 704 N Fo[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Auburn — DATE OF BURIAL, 12/30/22, 191.

20-UNDERTAKER Samuel Shewsky — ADDRESS 27 Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70584 D70584

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Russell St Hospital (ST.) (WARD)

2-FULL NAME Leannie Holmes

(a) RESIDENCE NO. Russell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of George W Holmes

6 DATE OF BIRTH (month, day, and year) July 8-1888

7 AGE: Years 34 Months 5 Days 19 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry McCoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary C. Dec 22 1922

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D. C.

14 Informant Mary E Jones

(Address) Russell & Bet Sts

15 DEC 30 1922 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1922 to Dec 27, 1922, that I last saw h alive on Dec 26, 1922, and that death occurred, on the date stated above, at 8.55 p m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Aortic Stenosis

(duration) — yrs. — mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic test

(Signed) R. H. Lamm, M. D.

(Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL 12/30/22

20 UNDERTAKER Samuel Hensley ADDRESS 528 N Bradford

Robert P. Garrison Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70585

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70585

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 Hanover ST.: 23 WARD)

2-FULL NAME Franz Alt.

(a) RESIDENCE. No. 1500 Hanover ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Lena Alt.

6 DATE OF BIRTH (month, day, and year) Jan 24 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator

(b) General nature of industry, business, or establishment in which employed (or employer) American Tobacco Co

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lena Alt
(Address) 1500 Hanover St

15 Filed ....., 19 .....
Registrar

EC 3 01922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1922

17 I HEREBY CERTIFY, That I attended deceased from 12.27.22, 19..., to 12.28.22, 19..., that I last saw h... alive on 12.28.22, 19..., and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic ~~Interstitial~~ Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical microscopic chemical test

(Signed) P Lilie S. Fowler, M. D.

12.30.22, 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan 1st 1923

20 UNDERTAKER: Mr Mrs. John H. Tuppel & Son — ADDRESS: 201 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70586

CERTIFICATE OF DEATH.

25-001

D70586

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1419 Anthony ST., 10 WARD)

2-FULL NAME Josph Schaff

(a) RESIDENCE NO. 1419 Anthony ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6-1920

7 AGE — Years: 1 — Months: 7 — Days: — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Jos N Schaeffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Pa

12 MAIDEN NAME OF MOTHER Irene Yeomans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Jos Schaeffer Sr

(Address) 1419 Anthony St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 27, 1922, to Dec 29, 1922,

that I last saw him alive on Dec 28, 1922

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Convulsions due to Auto Intoxication & Cellulitis of face & head

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Following Chicken pox

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) C B Carman, M. D.

12-29-1922 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dan Lan Cemetery

DATE OF BURIAL Dec 30 1922

20 UNDERTAKER Robt E Lemmon Inc

ADDRESS 14 & W Pratt

DEC 30 1922

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.- 1-10-21 M&T 1500 Blks.

D70587

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002

D70587

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3813 Pleasant Place WARD)

2-FULL NAME Baby Webb

(a) RESIDENCE NO. 3813 Pleasant Place WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 29 1922

7 AGE: Years ✓ Months ✓ Days ✓ If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER George Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lula Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George Webb

(Address) 3813 Pleasant Pl

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1922

17

I HEREBY CERTIFY, That I attended deceased from 12-29, 1922, to 12-29, 1922, that I last saw her alive on 12-29, 1922, and that death occurred, on the date stated above, at 6 30 p m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. F. Turnbull M. D.

12-30, 1922 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — DATE OF BURIAL Dec 30, 19 22

20 UNDERTAKER Chenowith Son — ADDRESS Chestnut ave

Report to Harrison, Burial Permit Clerk.

30 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70588-26 HEALTH DEPARTMENT—CITY OF BALTIMORE 118-02 D70588

D70588

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Gardner

(a) RESIDENCE NO. 2911 Cedar Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 2-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm. Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Redman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Johns Hopkins Hospital (Address) Boards

15 Filed, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1922

17

I HEREBY CERTIFY, That I attended deceased from 12-26-, 1922, to Dec, 28, 1922,

that I last saw him alive on Dec, 28, 1922,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Intussusception (Operation)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reisterstown Md DATE OF BURIAL Dec 30, 22

20 UNDERTAKER Chenoweth Son ADDRESS Chestnut Spa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

30 1922

Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70589

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70589

CERTIFICATE OF DEATH.

124

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Ehrhardt.

(a) RESIDENCE. NO. 1 Wyndhurst ave. ST.: Hamilton WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ehrhardt

6 DATE OF BIRTH (month, day, and year) May 3rd 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72 yrs.	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trucker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Maryland

PARENTS

10 NAME OF FATHER George Ehrhardt

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

11 Informant Hospital Records (Address)

15 Filed . 19 Registrar

DEC 30 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 19 22, to Dec 29, 19 22, that I last saw h[illegible] alive on Dec. 29, 19 22, and that death occurred, on the date stated above, at 10:5[illegible] m.

The CAUSE OF DEATH* was as follows:

Post-operative adhesions (appendectomy seven years ago)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericholecystitis - Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of Dec 14, 19[illegible]

Was there an autopsy? .....

What test confirmed diagnosis? operative findings

(Signed) Dr. Kelly, M. D.

19 [illegible] (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Jan 2 23

20 UNDERTAKER Fred. Loeffler & Sons ADDRESS Fullerton

Spec.—1-10-21—M&T—1500 Bks.

D70590

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70590

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 N. Rose ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Matzen

(a) RESIDENCE No. 513 N. Rose ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Matzen

6 DATE OF BIRTH (month, day, and year) Jan. 27th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Hoitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant John H. Matzen

(Address) 513 N Rose St

15 Filed ..... 19 ..... Registrar

30 1922

16 DATE OF DEATH (month, day, and year) Dec 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 23 1922, to Dec 27 1922, that I last saw h a alive on Dec 27 1922, and that death occurred, on the date stated above, at 12 45 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. ... mos 6 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Typ pneumococcus sepsis

(Signed) Post mortem, M. D.

, 19 (Address) 3015 Allewood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cemetery — DATE OF BURIAL: Dec 30 1922

20 UNDERTAKER: H. Vander & Sons — ADDRESS: 1710 Fleet St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70591 HEALTH DEPARTMENT—CITY OF BALTIMORE D70591

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 810 E. Broadway ST. 3 WARD)

2-FULL NAME Paul Louis Geier

(a) RESIDENCE NO. 810 E. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 - 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER August Geier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Pauline L. Rutling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant August Geier (Address) 810 E. Broadway

15 Filed Robert P. Harrison, Registrar

30 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1922, to Dec 28, 1922,

that I last saw him alive on Dec 28, 1922,

and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Aortic and Mitral Regurg.

(duration) some yrs. mos. days

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A. Rees, M. D.

, 19 (Address) 24 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Dec 31 1922
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should give

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70592 HEALTH DEPARTMENT—CITY OF BALTIMORE D70592

CERTIFICATE OF DEATH. 91-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2442 Callow ave. ST.; 13 WARD)

2-FULL NAME Jacob Greenbaum

(a) RESIDENCE. NO. 2442 Callow Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Greenbaum (deceased)

6 DATE OF BIRTH (month, day, and year) Nov 24 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant Clothing

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Greenbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Simon Greenbaum (Address) 2442 Callow ave

15 Filed DEC 30 1922 19 Robert F. Curtis Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 26 1922, to Dec 28 1922, that I last saw him alive on Dec 27 1922, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows: Pulmonary hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age, Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr. Greenwald M. D.

12/29, 1922 (Address) 1111 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	Dec 31 1922
20 UNDERTAKER J. Ahrens & Co	ADDRESS Pennsylvania

DEC 30 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

John Stankiewicz.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70593 HEALTH DEPARTMENT—CITY OF BALTIMORE D70593

CERTIFICATE OF DEATH. 100-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 So. Montford Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Stankiewicz

(a) RESIDENCE. No. 600 So. Montford Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? 1 yrs. 9 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26- 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Bronislaus Stankiewicz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Annie Kogut

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Bronislaus Stankiewicz
(Address) 600 So. Montford Ave.

Filed DEC 30 1922, 19 Robert J. Harrison
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-29 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28th, 1922, to Dec. 28th, 1922,
that I last saw him alive on , 1922,
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Jacob L. Winner, M. D.

12-29, 1922 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Dec 31. 1922
20 UNDERTAKER M. J. Sadowski.	ADDRESS 705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70594

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70594

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 Fleet St ST.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mieczslaw Siemek

(a) RESIDENCE. No. 2001 Fleet St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Dec 21-22

7 AGE: Years — Months — Days 8 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Stanislaw Siemek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Anna Kutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Stanislaw Siemek (Address) 2001 Fleet St.

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922, to Dec 29, 1922, that I last saw him alive on Dec 21, 1922, and that death occurred, on the date stated above, at 1.8 m.

The CAUSE OF DEATH* was as follows:

Premature birth - 8 Eight month

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Infant Premature birth - 8 Eight month

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

12/29, 1922. (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. — DATE OF BURIAL: Dec 31 1922.

20 UNDERTAKER: Jacob Jankowski — ADDRESS: 428 S Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

301922

Spec.—1-10-21—M&T—1500 Blks.

D70595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

D70595

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 5 WARD)

2-FULL NAME Sam Linton

(a) RESIDENCE NO. 1914 St. Mathews St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	-	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O+O

(c) Name of employer

9 BIRTHPLACE (city or town) Williamson Co., (State or country) Tenn.

PARENTS

10 NAME OF FATHER Pat Linton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant Municipal Hospital Records.

(Address)

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

DEC 30 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1922

17

I HEREBY CERTIFY, That I attended deceased from December 20, 1922, to December 27, 1922, that I last saw him alive on December 27, 1922, and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. & Lab. Tests

(Signed) Clyde M. Neill, M. D.

12/29/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner of Health,

DEC 30 1922

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70596

CERTIFICATE OF DEATH.

47

D70596

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hosp.

CITY OF BALTIMORE: (No. Eastern Ave ST., 17 WARD)

2-FULL NAME Mary E. Harris

(a) RESIDENCE NO. 586 Oxford ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8/3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE — Years: 60 — Months — Days — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pa

PARENTS

10 NAME OF FATHER: John Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country): ~~Unknown~~ Harford Co. Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co Md

14 Informant (Address): Municipal Hospital

15 Filed 3 1 1923, 19 — Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-28-1922

17 I HEREBY CERTIFY, That I attended deceased from 7-1-, 1922, to 12-28, 1922

that I last saw h[illegible] alive on 12-28, 1922

and that death occurred, on the date stated above, at 7:15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast (both) with metastases to glands in neck & both axilla

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Microscopic section of [illegible] glands

(Signed) J. Richards Wayne, M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pauldany

DATE OF BURIAL: 12-31 1922

20 UNDERTAKER: Grace H. Holland

ADDRESS: 1631 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70597 D70597

CERTIFICATE OF DEATH.

X 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 Whatcoat ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy A. Galloway

(a) RESIDENCE NO. 91 S Whatcoat ST. WARD Annapolis Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 15 1892

7 AGE: Years 30 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

070

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Lem Galloway

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lowinia Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Willemetter Smith

(Address) 910 Whatcoat st

15 Filed ..., 19 ... Registrar: Robert P. Harrison, Burial Permit Clerk.

C 30 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 26th, 1922, to Dec 28th, 1922, that I last saw h alive on Dec 28th, 1922, and that death occurred, on the date stated above, at 6:45 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. not known mos ds.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Annapolis md

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Harry T Brown, M. D.

, 19 (Address) 15 S Presstman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Md — DATE OF BURIAL 12/30/22, 19

20 UNDERTAKER: Samuel W. Chase-son — ADDRESS 1400 Mosher st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

70598 D70598

HEALTH DEPARTMENT—CITY OF BALTIMORE

70598 D70598

CERTIFICATE OF DEATH. X 100-001

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Greene & Lombard Sts, St.: W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss. Elizabeth Koch

(a) RESIDENCE. No. 702 York Road - Towson St., Md., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaking

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County
(State or country)

PARENTS

10 NAME OF FATHER Henry Koch

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Christiana Betz

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Henry Koch
(Address) 702 York Road Towson

15 Filed DEC 31 1922 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/29 1922

17 I HEREBY CERTIFY, That I attended deceased from 9/5, 1922, to 9/29, 1922, that I last saw her alive on 12/30, 1922, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) Wm Lister, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Presbyterian Cemetery,	Jan 2 1923
20 UNDERTAKER	ADDRESS
John Burns Sons	Towson, Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70599 31 D70599

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 946 W. Saratoga ST., 18 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marcus Kenney

(a) RESIDENCE NO. 946 W. Saratoga ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Kenney

6 DATE OF BIRTH (month, day, and year): 12, 18, 1868

7 AGE — Years: 55 — Months: — Days: 9 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer): 18

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Jacob Kenney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Charity Shelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Bettie Johnson

(Address): 660 Druid Park Dr

15 Filed DEC 31 1922, 19 ... ROBERT H. KINGTON, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 28 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922 to Dec 28, 1922

that I last saw him alive on Dec 28, 1922

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ... yrs. 10 mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Sputum Examination

(Signed) Jesse Lee Rae, M. D.

12/29/1922 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: 1/1 1923

20 UNDERTAKER: Jas. M. Skinner

ADDRESS: 1625 E. Madison St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70600

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D70600

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Stewart Ave ST., 27 WARD)

2-FULL NAME Mollie Bloom

(a) RESIDENCE No. 3 Stewart Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isidor Bloom

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER SAM SABINSKY

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Birtie Rosehery

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant J. Louis

(Address) 4339 Bucks St.

15 Filed DEC 31 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1922

17 I HEREBY CERTIFY, That I attended deceased from July, 19 22 to Dec. 30, 19 22, that I last saw h alive on Dec. 30, 19 22, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sput.

(Signed) Samuel Wolman M. D.

, 19 (Address) 2444 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL 12-31-192-

20 UNDERTAKER Jack Louis — ADDRESS 4339 E. Bucks

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70601

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D70601

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 E. Baltimore ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Greenberg

(a) RESIDENCE No. 1626 E. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 1 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Greenberg

6 DATE OF BIRTH (month, day, and year) July 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ladies Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E. Baltimore Street

15 Filed DEC 31 1921 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/30 1922

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to Dec 30 , 1922

that I last saw h[illegible] alive on Dec 30 , 1922,

and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Jack Lewis, M. D.

12/30 1922 (Address) 223 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodeph Shalom DATE OF BURIAL 1/3/22 1922

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Rheumatism

Spec.—6-9-19—H. P. Co.—1000 Blks.

D70602

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D70602

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1525 Linwood Ave ST.: 14 (WARD)

2-FULL NAME Joseph Klar

(a) RESIDENCE. NO. 1525 Linwood Ave ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 11 mos. ds. How long in U. S., if of foreign birth? / yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1-1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Bernie Klar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie Scherr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levin 1439 E Balto St

15 Filed DEC 31 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 192

17 I HEREBY CERTIFY, That I attended deceased from Dec 20 1922 to Dec 30 1922

that I last saw h.. alive on Dec 30 1922

and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Colitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1917

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Louis H. Coulter M. D.

Dec 30 192 (Address) 1500 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehrin Rosedale — DATE OF BURIAL 12/31 192

20 UNDERTAKER Jack Levin 1439 E Balto St — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D70603

HEALTH DEPARTMENT—CITY OF BALTIMORE

106-00 D70603

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 Bismore ST., 21 WARD)

2-FULL NAME George Wright

(a) RESIDENCE NO. 1117 Bismore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Rayfield Wright

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Mildred Egans

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) R. I.

14 Informant Mildred Egans.
(Address) 1117 Bismarck

15 Filed DEC 3 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29th 1922.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1922, to Dec. 29, 1922, that I last saw him alive on Dec 29, 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

following Bronchitis

(duration) yrs. ? mos ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) O. H. Cannon, M. D.

12/30 1922 (Address) 140 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Dec 31 1922
20 UNDERTAKER	ADDRESS 1 [illegible] St
John H. Soadner	[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70604

CERTIFICATE OF DEATH.

100-001

D70604

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1202 Mc Elderry ST.: 10 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clementine Pindell

(a) RESIDENCE. NO. 1202 Mc Elderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Daniel Pindell

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Winters

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mary Pindell
(Address) 1202 Mc Elderry St

15 Filed DEC 31 1922 ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1922, to Dec 28, 1922, that I last saw h alive on Dec 28, 19..., and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) 0 yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted
If not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jno Edward Fisher, M. D.

12 29 1922 (Address) 1612 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Dec 31 1922
20 UNDERTAKER	ADDRESS
Jno Robert A Elliott	1725 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70605

CERTIFICATE OF DEATH.

90 D70605

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 N Gilmor ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Kuba

(a) RESIDENCE NO. 1531 N Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a ~~Unmarried~~ widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Carrie Kuba

6 DATE OF BIRTH (month, day, and year): Aug 6 1846

7 AGE: Years 76 Months 4 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Maker. 017

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Not known

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ~~Not~~ known

14 Informant: Isabella Kuba

(Address): Hamilton Md

15 Filed DEC 31 1922 ROBERT R. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12- 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1922, to Dec 29, 1922, that I last saw him alive on Dec 28 1922, and that death occurred, on the date stated above, at 8 45 P m.

The CAUSE OF DEATH* was as follows:

Edema of Lungs

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles E Burke, M. D.

Dec 30, 1922 (Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 1- [illegible] 1923

20 UNDERTAKER: Mrs Chas A G Kolder — ADDRESS: 600 Hamilton Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70606 90 D70606

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH Pronounced Dead at 70

City of BALTIMORE: (No. Franklin Square Hospital St., ...Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gilbert C. Knight

(Residence in Baltimore: No. 1104 N. Loudon Ave St.; yrs. 32 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	Married

6-DATE OF BIRTH. October 15 1854
(Month) (Day) (Year)

7-AGE. 67 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Proof Reader
(b) General nature of industry, business, or establishment in which employed (or employer). Balt. News

9-BIRTHPLACE, (State or Country). Louisiana

PARENTS.

10-NAME OF FATHER. James Knight

11-BIRTHPLACE OF FATHER. (State or Country). Don't Know

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER. (State or Country). Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna C. Knight

(Address) 1104 N. Loudon Ave

15- ROBERT R. KRAUTH

Filed DEC 31 1922 Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 25 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

Contributory Chronic Diabetes

(Duration) yrs. mos. ds.

(Secondary) Heart (Duration) yrs. mos. ds.

(Signed) James H. Preston M. D.
(Coroner.)

Dec. 31 1922. (Address) 727 E. Chase St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	1/1/1923

20-UNDERTAKER. Wm Cook ADDRESS 502 E North Ave

is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

√ Murgatroyd & 25 Barcaly

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70607 D70607

CERTIFICATE OF DEATH. 45

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 455 Whitridge Ave ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth H. Baldwin

(a) RESIDENCE NO. 455 Whitridge ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of B. F. Baldwin

6 DATE OF BIRTH (month, day, and year) 3-11-1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	85	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Hampshire

PARENTS

10 NAME OF FATHER Jonathon Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. H.

12 MAIDEN NAME OF MOTHER Sarah Cofran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. H.

14 Informant Jamie E. Ball

(Address) 455 Whitridge

15 Filed DEC 31 1922, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) December 30 R 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15 R, 1922, to Dec 30 R, 1922.

that I last saw her alive on Dec 30 R, 1922,

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows: Carcinoma of Rectum

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible], M. D.

Dec 31 1922 (Address) 401 E. 15 R St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grafton W. Va

DATE OF BURIAL 1/2 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70608

CERTIFICATE OF DEATH.

38 D70608

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 Columbia Ave ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Wm Albrecht

(a) RESIDENCE NO. 725 Columbia Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 10 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Fredrica Albrecht

6 DATE OF BIRTH (month, day, and year) Feb 24 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dimoky Albrecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Leckner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fredrica Albrecht

(Address) 725 Columbia Ave

15 Filed DEC 31 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 19 22, to Dec 30, 19 22,

that I last saw h[illegible] alive on Dec 30, 19 22,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos 22 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

Dec 30, 19 22 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Jan 1 1923

20 UNDERTAKER Wm J. Leckner & Sons

ADDRESS North Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Emetic

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70609 D70609

CERTIFICATE OF DEATH.

89

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3433 Piedmont Ave. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. LeBrou

(a) RESIDENCE NO. 3433 Piedmont Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 9 mos. 21 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Scharnagle

6 DATE OF BIRTH (month, day, and year) Mar. 7, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Chandler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Capt. John F. LeBrou

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth M. Aitken

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Anna C. LeBrou
(Address) 3433 Piedmont Ave.

15 Filed ....., 19 .....

JAN 1 - 1923 ROBERT R. ARMUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29. 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 14th, 1922, to Dec. 29th, 1922, that I last saw h[illegible] alive on Dec 29th, 1922, and that death occurred, on the date stated above, at 12:45 p. m.

The CAUSE OF DEATH* was as follows:

Attack of Angina Pectoris. Hypertention, with Cardio-Hypertrofy & Interstitual Nephritis.

(duration) 4 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Sclerosis coronary arteries

(duration) 4 yrs. mos. - ds.

18 Where was disease contracted if not at place of death? — — —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? urinalysis analysis, Blood Pressure, Cardiac enlargement & attacks

(Signed) Amelia V. Zimmerman, M. D.

19 (Address) 1805 W north ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 1/2 1923

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D70610

D70610

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2910 Walbrook Avenue ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME C. Allen Orem

(a) RESIDENCE NO. 2910 Walbrook Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabel Henley

6 DATE OF BIRTH (month, day, and year) Sept. 10, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired - Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. City Fire Dept.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Alexander Orem

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Tingle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Isabel Orem (Address) 2910 Walbrook Avenue

15 Filed JAN 1 - 1923 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/28/1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1922, to Dec 28, 1922, that I last saw h[illegible] alive on Sunday 12/28, 1922, and that death occurred, on the date stated above, at 8P m.

The CAUSE OF DEATH was as follows:* Chronic Interstitial Nephritis

(duration) 2 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Uraemia Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) [illegible] M. D.

12/29/1922 Address 3328 Edmondson Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 1/1 1923

20 UNDERTAKER Henry W. Mears & Son 805 ADDRESS N. Calvert

Spec.—6-9-19—H. P. Co.—1000 Blks.

D70611 HEALTH DEPARTMENT—CITY OF BALTIMORE D70611

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 908 N. Monroe St. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Ann Nelson

(a) RESIDENCE. NO. 908 N. Monroe St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Horace B. Nelson

6 DATE OF BIRTH (month, day, and year): July 7 1842

7 AGE: Years 80 Months 5 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Hannah Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Roy Nelson (Address) 300 E. 24th St.

Filed JAN 1 - 1923 ROBERT R. KRAUTH, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec-30 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec-27, 1922, to Dec 30, 1922, that I last saw h alive on Dec-30, 1922, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W. Hunter, M. D.

, 19 (Address) 304 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kingsley Chapel Cemetery Co. Kingsley Chapel Church Yd. DATE OF BURIAL: Jan. 1st 1923

20 UNDERTAKER: Wilbur W. Shriver. ADDRESS: 1018 Edmondson Ave.

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70612

HEALTH DEPARTMENT—CITY

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 N. Carey St. ST.: 14 W... ...d of street a... ...ber.)

2-FULL NAME Fannie Belle Maslin

(a) RESIDENCE. No. 214 N. Carey St. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos. ... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Samuel G. Maslin

6 DATE OF BIRTH (month, day, and year) Sept 26 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	3	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William S. Godwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Travelon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

11 Informant Mary E. Godwin
(Address) 214 N. Carey St.

15 Filed JAN 1 — 1923 ROBERT R. KNAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31, 19 2...

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 19 22 to Dec 31, 19 22
that I last saw h... alive on Dec 30, 19 22
and that death occurred, on the date stated above, at 12.25 a. m.
The CAUSE OF DEATH* was as follows:

Carcinomatosis

(duration) yrs. 2 mos. 26 ds.

CONTRIBUTORY (Secondary) Toxaemia. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of "7"
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) George Abner Bowden, M. D.
12/2 1922 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chesterlown Cemetery	Jan. 2 1923

20 UNDERTAKER Wilbur W... /ADDRESS

MARGIN RESERVED FOR BINDING

. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed given up on account of the DISEASE CAUSING DEATH, occupation at beginning of illness. If retired, business, that fact may be indicated thus: (*retired, 6 yrs.*). For persons who have no n whatever, write *None*.

f cause of death.—Name, first, the DEATH (the primary affection with nd causation), using always the r the same disease. Examples: (the only definite synonym is rospinal meningitis"); *Diphtheria* "Croup"); *Typhoid fever* (never re- d pneumonia"); *Lobar pneumonia* nonia ("Pneumonia," unqualified, is *Tuberculosis of lungs, meninges, peri-*
Carcinoma, Sarcoma, etc., of.....
"Cancer" is less definite; avoid use of **malignant neoplasms**); **Measles**; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Patient had left breast removed over a year ago for carcinoma. Has developed general carcinomatosis since then.

G. A. Bender M.D.

6/13/21

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70613

CERTIFICATE OF DEATH.

91-002

D70613

1-PLACE OF DEATH Michigan Ave & Bloom

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Manchester Apts ST., 14 WARD)

2-FULL NAME Simon Sinsheimer

(a) RESIDENCE NO. Manchester Apts ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Matelda

6 DATE OF BIRTH (month, day, and year): Aug 8 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): ....

(c) Name of employer: ....

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Adolph

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Louis A Sinsheimer Georgian Court Apts

15 Filed 1-1 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-30 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1922, to Dec 30, 1922, that I last saw h[illegible] alive on Dec 30, 1922, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Oedema of lungs

(duration) yrs. 6 mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I Frederick Lutz, M. D.

12-31, 1922 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship

DATE OF BURIAL: 1-1 1923

20 UNDERTAKER: David Sondheim

ADDRESS: 410 W Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

No 3992 Miss Reach

70612 D70614

HEALTH DEPARTMENT—CITY OF BALTIMORE

34

70612 D70614

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 726 N Caroline St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Registered No. C.....

2-FULL NAME..... Elsie Young

(Residence in Baltimore: No. 726 N Caroline St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, ~~Married~~, Widowed, or Divorced, (Write the word.) W

6-DATE OF BIRTH, July 15 (Month) (Day) 1887 (Year)

7-AGE, 35 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Eaton

9-BIRTHPLACE, (State or Country) East New Market Md

PARENTS.

10-NAME OF FATHER, George W. Young

11-BIRTHPLACE OF FATHER, (State or Country) East New Market Md

12-MAIDEN NAME OF MOTHER, Mary Young

13-BIRTHPLACE OF MOTHER, (State or Country) East City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Young

(Address) Seaford Del.

15- Robert P. Harrison, Filed 192 Registrar.

1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 29 (Month) (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Duration yrs. mos. ds.

Pneumonia

CONTRIBUTORY (Secondary) Duration yrs. mos. ds.

(Signed) Geo Elston Pledger M. D.

(Coroner.) 192 (Address) 1436 Bway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, East New Market Co Md — DATE OF BURIAL, Jan 2 1923

20-UNDERTAKER, Robert E Williams — ADDRESS 1515 McElderry St

is very important. See instructions on back of certificate.

Was [illegible] progressive Mrs Young Tubercular Adenitis

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70615 D70615

CERTIFICATE OF DEATH. X 114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs Cora Pfeiffer

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28 WARD. (near Waynesboro-Penna)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? 42 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Pfeiffer

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
Abt	42	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Rugold Md-

PARENTS

10 NAME OF FATHER Henry Shockey

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) (?)

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) (?)

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md-

15 1923 Jan 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 17, 1922, to Dec 31, 1922, that I last saw h.. alive on Dec 31, 1922, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

Abt (duration) abt yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Mania Psychosis (duration) — yrs. 1 mos. ? ds.

18 Where was disease contracted if not at place of death? Greencastle Pa

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Frank J Filaminy, M. D.

, 19 (Address) Mt Hope Retreat-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rices Church near Waynesboro Pa

DATE OF BURIAL 19

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

CAUSE OF DEATH to be plainly written, and no abbreviations used. Every question must be answered. Every statement must be complete. Every blank must be properly filled. Every certificate must be signed. Every signature must be witnessed. Every witness must be identified. Every identification must be verified. Every verification must be notarized. Every notarization must be sealed. Every seal must be authenticated. Every authentication must be recorded. Every record must be filed. Every file must be indexed. Every index must be cross-referenced. Every cross-reference

Spec.—1-10-21—M&T—1500 Bks.

D70616

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70616

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221-Bolton-St. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Augusta Valiant

(a) RESIDENCE NO. 1221-Bolton-St. ST., 11 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? 68 yrs. 4 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (None) (Single)

6 DATE OF BIRTH (month, day, and year) Aug-9-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	68	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher.

(b) General nature of industry, business, or establishment in which employed (or employer) Public Schools.

(c) Name of employer Baltimore City.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER James Valiant.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER ElizabethDelebett

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant Mr. Wm. G. Robertson, (nephew)
(Address) 6212-York Road, City.

15 Filed 1-, 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 29, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17th, 1922, to Dec. 29th, 1922, that I last saw h[illegible] alive on Dec. 28th, 1922, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Endo-Carditi's
of several days
(duration) ~~yrs.~~ ~~mos.~~ ~~ds.~~

CONTRIBUTORY (Secondary) Acute indigestion
(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms.

(Signed) Claude C. Trott, M. D.

12-30, 1922 (Address) 1012 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK CEMETERY — DATE OF BURIAL: Jan-1-23

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 103 W. NORTH AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D70617

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70617

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 N. Carey St. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel R. Duvall

(a) RESIDENCE NO. 228 N. Carey St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Duvall

6 DATE OF BIRTH (month, day, and year) Sept. 23" 1837

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
85	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor of Shoe

(b) General nature of Industry, business, or establishment in which employed (or employer) Store

(c) Name of employer

9 BIRTHPLACE (city or town) Howard County

(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Duvall

11 BIRTHPLACE OF FATHER (city or town)

(State or country) France

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Dr. and Mrs. H. Phillips

(Address) 228 N. Carey St.

F-1923 Robert F. Carrick

Filed ..... 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30" 19 22

17

I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1922, to Dec. 30, 1922, that I last saw him alive on Dec. 28, 1922, and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs and symptoms.

(Signed) Charles Lee, M. D.

12/30 19 22 (Address) 1111 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Jan 1st 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bolton St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

AN

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70618 90 D70618

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2138 N Northern Pk. 15 WARD)

2-FULL NAME Mrs H Zeegler

(a) RESIDENCE NO. 2138 N North ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ellen Zeegler

6 DATE OF BIRTH (month, day, and year) June 1 1837

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER Henry Zeegler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Benzenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Daisy C Zeegler
(Address) 2138 N Front Ave

15 Filed 1923, 19 Robert P. Bartlett Registrar

Vital Records Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 192.., to Dec 30, 1922.

that I last saw h alive on Dec 30, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Hydropericardium

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symp

(Signed) John T Geary M. D.

, 19 (Address) 101 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem | DATE OF BURIAL Jan 2nd 1923

20 UNDERTAKER Joseph B Cole | ADDRESS 1003 N Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 - M&T 1500 Blks.

D70619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70619

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 847 W. Lombard St. ST., 18 WARD)

2-FULL NAME Edward Thomas Diven

(a) RESIDENCE NO. 847 W. Lombard St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Diven

6 DATE OF BIRTH (month, day, and year) Dec. 11" 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	84	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Stationary

(b) General nature of industry, business, or establishment in which employed (or employer) Engineer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Elias Diven

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Ann Parson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mrs. Mary Diven (Address) 847 W. Lombard St.

15 Robert P. Harrison, 19 Registrar

1-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 19 22

17

I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922, to Dec 28, 19 22.

that I last saw him alive on Dec 28, 19 22

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clifford Dowell M. D.

12/29, 19 22 (Address) 1227 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan. 1st 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bulto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70620 51 D70620

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 10 S. Poppleton St. (St.) 18 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Irene Reilly

(a) RESIDENCE NO. 10 S. Poppleton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 2 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	----	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John J. Reilly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ella Duff

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Ella Reilly
(Address) 10 S. Poppleton St.

15 Filed 1 1923 Roberta P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/20/22, 19..., to 12/30/22, 19...,

that I last saw h.. alive on 12/30/22, 19...,

and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

History

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel Levy, M. D.

12/31/1922 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL Jan 2, 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CONDITION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital Heart &
frequent attacks of
Rheumatic Fever
Probably due to bad
Tonsils.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70621 D70621

CERTIFICATE OF DEATH. 101-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Shirley Meyer

(Residence in Baltimore: No. 1518 E. Lombard St.; ..... yrs., 19 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) January (Day) 1 (Year) 1903

7-AGE, 19 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Louis Cohen

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Anna Gear

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E. Baltimore

15- Robert P. Harrison,

Filed ....., 191.....

1923 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH December (Month) 31 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1922, to Dec. 31 1922, that I saw her alive on Dec. 31 1922, and that death occurred, on the date stated above, at 9.50 Am.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart

(sudden)

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 25 ds.

(Signed) Ernest Callander M. D.

1/1, 1923 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rodeph Sholom DATE OF BURIAL, Jan. 1, 1923

20-UNDERTAKER Jack Levine ADDRESS 1439 E. Baltimore

Important.—See instructions on back of certificate.

D70622

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

99-001 D70622

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 17 Pera St., 4 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Clarence J. Morris

(Residence in Baltimore: No. 17 Pera St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. Oct (Month) 3 (Day) 1921 (Year)

7-AGE.	If LESS than 1 day,
1 yrs. 2 mos. 27 ds.	....brs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Joseph Morris

11-BIRTHPLACE OF FATHER, (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Rebecca Gaines

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Morris

(Address) 17 Pera St

15

Dec 1922 192.. Robert P. Hartman, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 31 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

caused by the following Ventricular Hemorrhage

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Emory M. Lawton M. D. (Coroner.)

Jan 31 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem.	1/1 1922
20-UNDERTAKER, Samuel Hensley	ADDRESS 378 N Eden St.

is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70623

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70623

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 253-S - Bethel ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Matthews

(a) RESIDENCE No. 253-S-Bethel ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Matthews

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) Washing & clean

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Denis Boston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Weems

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Richard Matthews

(Address) 253 S Bethel st

15 Robert P. Harrison, Registrar

1-1922 .19 ..... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-29-1921

17

I HEREBY CERTIFY, That I attended deceased from 12-28-, 1921, to 12-29-, 1921,

that I last saw h alive on 12-28-, 1921,

and that death occurred, on the date stated above, at 6,30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Mutual Insurance

(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Tom Cargill, M. D.

12-31 1921 (Address) 611-N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion

DATE OF BURIAL Jan 1 1922

20 UNDERTAKER John A Henderson

ADDRESS 1502 E Monument

CAUSE OF DEATH to be plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Indirection of eating. No other history.

William D. Cramer

D70624

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70624

CERTIFICATE OF DEATH.

Registered No. C 13 128

1-PLACE OF DEATH

City of BALTIMORE: (No. William D University Hospital St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. William D. Cramer

(Residence in Baltimore: No. 1517 Baldwin St. St.; 7 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. April (Month) 24 (Day) 1900 (Year)

7-AGE. 22 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boiler maker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Wm J. Cramer

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Carrie Grimm

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Cramer

(Address) 1517 Baldwin St

15- Robert F. Harrison, Registrar.

Filed 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 31 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed) H. R. Gamrath M. D. (Coroner.)

1-1 1923 (Address) 117 W. Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Poplar Pa. DATE OF BURIAL. Jan 2 1923

20-UNDERTAKER. Kenworthy & Son ADDRESS Chestnut ave

1 is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70625

D70625

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1306 Longwood ST.: 16 WARD)

2-FULL NAME William R. Wonderly

(a) RESIDENCE. NO. 1306 Longwood ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 20/1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ticket agent

(b) General nature of industry, business, or establishment in which employed (or employer) W.B.&A. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Geo L. Wonderly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Isabelle Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant Mrs John Hieber
(Address) 1306 Longwood St

15 Filed JAN 1 1922, 19 ..... Registrar

ROBERT F. CARLSON,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-31-22 19

17 I HEREBY CERTIFY, That I attended deceased from Nov ....., 1922 to Dec-31 ....., 1922

that I last saw h[illegible] alive on Dec-30 ....., 1922

and that death occurred, on the date stated above, at 3:a 12½

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) T K Franck, M. D.

1-1-1923 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Jan 2 1923

20 UNDERTAKER Chas. E. Franck

ADDRESS for Madeira

Note.—Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70626 D70626

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 W. Lombard St ST. 14 WARD)

2-FULL NAME Walter Alvin Gamble.

(a) RESIDENCE NO 1422 W. Lombard St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug 1877

7 AGE — Years: 45 — Months: 4 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: Wasson Transfer Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Chas E. Gamble

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Mary Corrigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary J. Smith
(Address) 2411 Pompeo E. Side

15 Filed ..... 19 ..... Registrar

1-1-1923

Robert E. Garrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1922, to Dec 30, 1922, that I last saw him alive on Dec 30, 1922, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. 3 mos 18 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Nasal Dept

(Signed) Robt J. Mulvoy, M. D.

1-1, 1922 (Address) 510 W. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Jany 2" 1923

20 UNDERTAKER: Wm J. Hartwell — ADDRESS 2256 W. Baltimore St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

70627 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D70627

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Division ST., 14 WARD) 100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Andrew J. Jones

(a) RESIDENCE NO. Glenwilton, Va. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 weeks ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ky.
(State or country)

PARENTS

10 NAME OF FATHER John Jones.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ohio

12 MAIDEN NAME OF MOTHER Josephine Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant James D. Moss
(Address) Clifton Forge Va

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1923

17 I HEREBY CERTIFY, That I attended deceased from 12-8, 1922, to 1-1, 1923, that I last saw him alive on 1-1, 1923, and that death occurred, on the date stated above, at 9-20 a m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12-18-22

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) A B Price, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clifton Forge Va — DATE OF BURIAL 1/1 1923

20 UNDERTAKER Wm Cook — ADDRESS Clifton Forge Va

1 1923 Robert P. Garrison Registrar

TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for Adhesions
& Duodenal Ulcer

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70628 D70628

CERTIFICATE OF DEATH. — 46

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1820 Fulton Ave ST. 15 WARD)

2-FULL NAME Sarah Senn

(a) RESIDENCE No. 1820 Fulton ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 15-1857

7 AGE — Years: 65 y — Months — Days — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Balto Maryland

PARENTS

10 NAME OF FATHER: John Mayhew

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah Hayward

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mary V. Browning
(Address): 820 N. Fulton

15 Filed ....., 19 ..... Registrar

Robert E. Garrison, Burial Permit Clerk.

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 31 1922

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1922, to Dec 31, 1922, that I last saw h alive on Dec 30, 1922 and that death occurred, on the date stated above, at 6.20 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus
& Intestines.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ..... (duration) ~~11~~ yrs. 12 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) John A. Crabb, M. D.

19 (Address) 101 N. Caroy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 1/2/23

20 UNDERTAKER: Wm Cook's — ADDRESS: 502 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of DISEASE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Watson 2128 St Paul

D70629

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D70629

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2306 N. Charles ST. V WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lina Straugmann

(a) RESIDENCE NO. 2306 N. Charles ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (~~HUSBAND of~~ or) WIFE of: Robert C. Straugmann

6 DATE OF BIRTH (month, day, and year): Nov 19 - 1870

7 AGE: Years: 52 | Months: | Days: | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Herman Ayres

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Bodenwick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: R. C. Straugmann

(Address): 2306 N. Charles

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12-31 1922

17

I HEREBY CERTIFY, That I attended deceased from October 15, 1922, to Dec 31, 1922,

that I last saw her alive on Dec 29, 1922,

and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Cancer of liver and stomach.

Secondary to Cancer of colon removed 1 year ago.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 1 year ago

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Wm J Watson, M. D.

Dec 31, 1922 (Address) 2128 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 1/2 - 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Monument

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70630 D70630

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Homewood Hosp. 222 (ST.) N. Charles St (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Mollenhagen Gaither

(a) RESIDENCE NO. 1624 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

TION is very imprtant. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm R. Gaither

6 DATE OF BIRTH (month, day, and year): May 25 1878

7 AGE: Years 44 Months 7 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Cincinatti Ohio

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Wm R. Gaither

(Address) 1624 Hollins St

15 Filed ..... 19 .....

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 31 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1922 to Dec. 31, 1922, that I last saw her alive on Dec. 31, 1922, and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1624 Hollins St

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Vernon H Condon, M. D.

, 19 (Address) 750 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem — DATE OF BURIAL: Jan 4 1923

20 UNDERTAKER: George J Smith — ADDRESS: Hollins

SL 0212

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70631 D70631

CERTIFICATE OF DEATH. 118-002

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1143 Cleveland ST., 21 WARD)

2-FULL NAME Geo P Sperlein

(a) RESIDENCE NO. 1143 Cleveland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 10 - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 00

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Philip S Sperlein

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Helen Hargadon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Helen Sperlein
(Address) 1143 Cleveland st

15 Filed ..... 19 .....
Robert F. Carrison
Burial Permit Clerk Registrar

1 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/28 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 19 22, to Dec 28, 19 22,
that I last saw h alive on Dec 28, 19 22,
and that death occurred, on the date stated above, at 1 00 m.
The CAUSE OF DEATH* was as follows:

Uremic suppression

(duration) yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) Convulsions 6 hours
(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Millard Brain, M. D.
19 (Address) 1 Mt Wash Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Jan 1 1923

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins st

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70632

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D70632

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3404 Gough ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phillip Lindenstruth

(a) RESIDENCE NO. 3404 Gough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Minnie Lindenstruth

6 DATE OF BIRTH (month, day, and year): Jan. 28-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Expressman

(b) General nature of industry, business, or establishment in which employed (or employer): 886

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Wm. Lindenstruth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Minnie Lindenstruth

(Address): 3404 Gough St.

15 Robert P. Garrison, Registrar

Burial Permit Clerk.

1-1923

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1922, to Dec 30, 1922, that I last saw him alive on Dec. 30, 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion
Hemorrhage Bronchial

(duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Lobar Pneumonia (duration) X yrs. X mos. 4 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Same.

(Signed) Jas. L. Kinear, M. D.

Dec 31, 1922 (Address) 248 So 3d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Matthews Cem.	Jan. 2 1923
20 UNDERTAKER	ADDRESS
Zirkler & Zirkler	1739 E. Eager St.

D70633 HEALTH DEPARTMENT—CITY OF BALTIMORE D70633

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. University Hospital St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Rostor Barlow

(Residence in Baltimore: No. 504 N Barrr St St.; (yrs., 10) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Dec (Month) 2 (Day) 1892 (Year)

7-AGE.	If LESS than 1 day,
30 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Tailor
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Joseph Barlow

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine Barlow

(Address) 504 N Barrr st

15- Robert P. Harrison,

Filed ..... 192.. Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 30 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ Inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or~~ Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) 4 hours

CONTRIBUTORY (Secondary) Don't Know

~~(Duration)~~ ..... yrs. ..... mos. ..... ds.

(Signed) H K Jones M. D. (Coroner.)

12-31 1922 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
[illegible]	1923
20-UNDERTAKER.	ADDRESS
[illegible]	[illegible]

1-1923

P. 0117

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70634 ✓ D70634

D70634

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 710½ E Lafayette St. (Ward) 6

2-FULL NAME George Wisse

(a) RESIDENCE NO. 710½ E Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Wisse

6 DATE OF BIRTH (month, day, and year): July 10 - 1858

7 AGE: Years 64; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Soldier

(b) General nature of industry, business, or establishment in which employed (or employer): 871

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: George Wisse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Scheff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mary Wisse 710½ E Lafayette St

15 1923 ROBERT P. HARRISON, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 29 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to Dec 29, 1922, that I last saw him alive on Dec 28, 1922, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John F Avery, M. D.

19 (Address) 1603 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: July 23 1923

20 UNDERTAKER: Clark & Tanner

ADDRESS: W. Baltimore

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70635

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70635

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 Frederick Av ST., 70 WARD)

2-FULL NAME Kate E. Uherrett

(a) RESIDENCE NO. 1804 Frederick av ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

137

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Henry L. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Susan Timmins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mr. H. Uherrett

(Address) 1804 Frederick av

15 ..... 1-1923 ....., 19 .....

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 23, 1922, to Dec 29, 1922

that I last saw her alive on Dec 29, 1922

and that death occurred, on the date stated above, at 3.35 m.

The CAUSE OF DEATH* was as follows:

chronic interstitial nephritis

(duration) yrs. mos. unknown ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter A Cox, M. D.

(Address) 571 Fulton av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Jan 1st 1923

20 UNDERTAKER: A. Jones

ADDRESS: 111 S. Gilmor st

CAUSE OF DEATH must be plainly written, so that it may be properly classified. Each statement of fact is very important. See instructions on back of certificates.

D70636

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70636

CERTIFICATE OF DEATH.

1923 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Saml Tucker

(Residence in Baltimore: No. 816 Dill ave St.; 20 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Mard

6-DATE OF BIRTH. June (Month) 27 (Day) 1889 (Year)

7-AGE. 33 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer) 152

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Saml Tucker

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary Hagers

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L. Neale (Mother)

(Address) 1624-15th St. N.W. Washington DC

15- Filed 1923 Robert P. Harrison, Registrar.

Deputy Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec (Month) 22 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to Instantaneous death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shot a Bullet wound in his chest
Shot from a Pistol in the hands of
Unknown person at this time unknown

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Gonzales M. D. (Coroner.)

12-31 192 2 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cemetery

DATE OF BURIAL. Dec 24 1923

20-UNDERTAKER. Jno. M. Johnson

ADDRESS 1234 Eutaw St.

If very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70637

CERTIFICATE OF DEATH.

90 D70637

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 W Fayette ST.: 18 WARD)

2-FULL NAME Margaret Meade

(a) RESIDENCE. NO. 937 W Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wht	Mar.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 30 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md Patrick Gunnon

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant C Meade
(Address) 937 W Fayette

15 Filed . 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922, to Dec 31, 1922, that I last saw h alive on Dec 30, 1922, and that death occurred, on the date stated above, at 5 40 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmn Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F Norwood, M. D.

Jan. 3, 1923 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 3 1923

20 UNDERTAKER Geo. J. Smith

ADDRESS 1008 W. Fayette

Spec.—1-10-21—M&T—1500 Bks.

(Schmidt)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70638

CERTIFICATE OF DEATH.

129

D70638

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1939 W Baltimore St. 20 WARD)

2-FULL NAME Mary E. Schmidt

(a) RESIDENCE NO. 1939 W Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: A J Schmidt

6 DATE OF BIRTH (month, day, and year): Feb 9 1868

7 AGE: Years 54 — Months 10 — Days 20 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Anthony Caymann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Hannah Caymann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): A J Schmidt 1939 W Baltimore st.

15 Dec 30 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 29 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 30, 1923, to Dec. 29, 1923,

that I last saw her alive on Dec. 23, 1923,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus.

10 min.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis - Arteriosclerosis (duration) 10 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) William Michel, M. D.

Dec 31 1923 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 1/2/23

20 UNDERTAKER: George W Fuhrman — ADDRESS: Fayette

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70639

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70639

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Hollins ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin F Clark

(a) RESIDENCE No. 922 Hollins ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Clark

6 DATE OF BIRTH (month, day, and year) Jan 24 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) R Road

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Lenora E Clark

(Address) 922 Hollins

15 1923 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 12, 1922, to Dec 31, 1922,

that I last saw him alive on Dec 30, 1922,

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John L Waff M. D.

, 19 (Address) 1643 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL 1/27 23 19

20 UNDERTAKER Leopold Finley Fulton & Fayette

ADDRESS

TION is very important. See instructions on back of certificates.

D70640 HEALTH DEPARTMENT—CITY OF BALTIMORE D70640

CERTIFICATE OF DEATH. 49

1-PLACE OF DEATH City of BALTIMORE: (No. Johns Hopkins Hospital St., Ward) Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Louis K. Kellenberger

(Residence in Baltimore: No. 2402 Fredrick Ave St.; yrs., 47 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, Dec. (Month) 15 (Day) 1875 (Year)

7-AGE, 47 yrs. mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Benj. Kellenberger

11-BIRTHPLACE OF FATHER, (State or Country), England

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis A. Bregel

(Address) 2402 Frederick Ave.

15- Filed 1923 Robert P. Harrison, 192 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 29 (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Lung

(Duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(Duration) yrs. mos. ds.

(Signed) Geo. Elmer Bibbes M.D.

(Coroner.)

Dec 29 192 2 (Address) 1431 N Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dr Olivet DATE OF BURIAL. Dec 1 19 23

20-UNDERTAKER, George L. Schwab ADDRESS 2101 Fredk Ave

IS VERY important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70641

100-00

D70641

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Brehms Lane ST., 8 WARD)

2-FULL NAME Frederick Hofstetter Jr.

(a) RESIDENCE NO. 8 Brehms Lane ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 19 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 11 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
			19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frederick H. Hofstetter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Teresa Stallman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr. Frederick H. Hofstetter
(Address) 8 Brehms Lane

15 1-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 29th, 1922, to Dec 30th, 1922, that I last saw him alive on Dec 30th, and that death occurred, on the date stated above, at 10.35 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Physical signs

(Signed) Edw. H. Benson, M. D.

Dec 31 1922 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 2 1923
20 UNDERTAKER	ADDRESS
Henry Hoeck (Lee)	1301 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—6-9-19—H. P. Co.—1000 Bks.

70642

HEALTH DEPARTMENT—CITY OF BALTIMORE

70642

D70642

CERTIFICATE OF DEATH.

41 D70642

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1342 Glyndon Ave ST.: 21 WARD)

2-FULL NAME Adele Matelis

(a) RESIDENCE. NO. 1342 Glyndon ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY. Words should be fully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Singe

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Matelis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Stela Simkute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Joseph Matelis

(Address) 1342 Glyndon ave

15 Filed JAN 2 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31, 1922

17

I HEREBY CERTIFY, That I attended deceased from August 17, 1922, to December 31, 1922, that I last saw her alive on December 31, 1922, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis due to non-puerperal Septicaemia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Paraplegia, following injury at birth with extensive decubitus of the right hip joint. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronushas, M. D.

12-31, 1922 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 3 1923

20 UNDERTAKER ADDRESS

John Grebliunas 425 S. Paca St

Spec.—1-10-21—M&T—1500 Bks.

70643 HEALTH DEPARTMENT—CITY OF BALTIMORE 70643

D70643 CERTIFICATE OF DEATH. 161-001 D70643

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore & Third ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis J Robinson

(a) RESIDENCE No. Baltimore & Third ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~: Baby

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of):

6 DATE OF BIRTH (month, day, and year): Dec 17-1922

7 AGE: Years — Months — Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James W. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Julia L. Morgenroth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: James W. Robinson (Address): Baltimore & Third

15 JAN 2-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/30 1922

17 I HEREBY CERTIFY, That I attended deceased from 12/27/22, 19 . to 12/30/22, 19 .

that I last saw him alive on 12/30/22, 19 ,

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. D. Herrman M. D.

12/31/22 (Address) 1919 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery DATE OF BURIAL Jan 2-1922

20 UNDERTAKER: Wm C. Miller ADDRESS 2334 E Lafayette

mation should be carefully supplied. Any blanks not properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

70644 HEALTH DEPARTMENT—CITY OF BALTIMORE 70644

D70644 CERTIFICATE OF DEATH. 90 D70644

1-PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 703 E 20th ST.: 9 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Stevens

(a) RESIDENCE. No. 703 E 20th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edw J. Stevens

6 DATE OF BIRTH (month, day, and year) April 23 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER P. M. Holbrook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Grey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Anderson (Address) 2 New Gate

15 Filed JAN 2 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30. 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1922, to Dec. 30, 1922, that I last saw h[er] alive on , 1922, and that death occurred, on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration &
Cor pulmo

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema & Senility

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George A. Hartman, M. D.

(Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Jan 2 1923
20 UNDERTAKER C. A. Winfield Jr.	ADDRESS 501 E 22d

mation should be carefully supplied. Age, Name of Father, Maiden Name of Mother, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Schweigtenberg

70645 / 70645

70645
D70645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 D70645

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 N Durham ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Schweigtenberg

(a) RESIDENCE NO. 1623 N Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DECEASE'S TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Schweigtenberg

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): Watchman

(c) Name of employer: Wurzner Brewery

162

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Fred. William Schweigtenberg (Address) 1623 N. Durham St.

15 Filed JAN 2 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 23, 1922, to Dec 30, 1922,

that I last saw h~~im~~ alive on Dec 30, 1922,

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

(duration) 18 yrs. mos. ds.

CONTRIBUTORY (Secondary) Infirmities of age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Dr. O. Cannan, M. D.

12-31, 1922 (Address) 1707 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: Jan 2nd 1923

20 UNDERTAKER: Leo G. Cook

ADDRESS: North Harford

D 70646 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D70646

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 124 Virginia ave St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen W. Mann.

(Residence in Baltimore: No. 124 Virginia ave St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F)	W.	Widow

6-DATE OF BIRTH, Aug 4 (Month) / 1856 (Day) , 1856 (Year)

7-AGE, 66 yrs. 4 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home.
(b) General nature of industry, business, or establishment in whieb employed (or employer).....

9-BIRTHPLACE. (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, Wm. Watt

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Mary Fair

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Mann.

(Address) 124 Virginia ave.

15-

Filed ....., 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

2-1923

Important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 31 (Month) / 22 (Day) , 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apopalexy

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) [signature] M. D.
(Coroner.)

Jan 11, 1923 (Address) 263 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	Jan 24, 1923
20-UNDERTAKER	ADDRESS
J. A. Mitchell	1201 W Fayette

Spec.—8-24-14—M. & T.—2000 lbs.

(Alice A Crandell)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70647

CERTIFICATE OF DEATH.

100-001 D70647

REGISTERED No. C.....

1-PLACE OF DEATH Homewood Hosp.

CITY OF BALTIMORE: (No. 2724 N Charles St., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice A Crandell

(Residence in Baltimore: No. 2924 N Monroe St.; ..yrs,..mos..ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~MARRIED, SINGLE, WIDOWED, OR DIVORCED,~~ (Write the word.)

6-DATE OF BIRTH, ~~Dec~~ (Month) 5 (Day), 1841 (Year)

7-AGE 81 yrs. 4 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Edwin Leach

(Address) 3505 Berwyn Ave

15-

Filed JAN 2-1923 191... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~Dec~~ Jan 1 (Month) (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1922, to Jan 1 1923, that I saw h~~e~~ alive on Jan 1 1923, and that death occurred, on the date stated above, at 7.20 p.m.

The CAUSE OF DEATH* was as follows:—

Pneumonia

..... (Duration) ...yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ...yrs. 1 mos. ...ds.

(Signed) Fred F Mackert M. D.

1/1/23 191... (Address) 2724 N Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Green Mount

DATE OF BURIAL, Jan 3..., 1923

20-UNDERTAKER John D Mitchell

ADDRESS 1201 W Fayette St

Spec.—8-24-14—M. & T.—2000 Bks.

D70648

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D70648

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 E Fort Ave ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nowis E Hurley Jr

(Residence in Baltimore: No. 303 E Fort Ave St.; .....yrs., ...mos. .....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Oct (Month) 23 (Day), 1922 (Year)

7-AGE, ...yrs. 2 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Nowis E Hurley Jr

11-BIRTHPLACE OF FATHER (State or Country), Cecil Co

12-MAIDEN NAME OF MOTHER Nannie McKiggins

13-BIRTHPLACE OF MOTHER (State or Country), Dorchester Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nowis E Hurley

(Address) 303 E Fort Ave

15- JAN 2 - 1923 Filed....., 191.....

ROBERT R. KRAUFER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 1 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 29 191, to Jan 1 23 191, that I saw h him alive on Jan 1 23 191, and that death occurred, on the date stated above, at 9 45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration).....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) John F Hall M. D.

Jan 1 23 191... (Address) 1203 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, Jan 3 1923

20-UNDERTAKER, John J Fields

ADDRESS 1200 N Fulton Ave

Spec.—1-10-21—M&T—1500 Blks.

D70649

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70649

CERTIFICATE OF DEATH. 74-001

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 S Collington Ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Fleming

(a) RESIDENCE NO 223 S. Collington Av ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
About 79 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H W.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John B Fleming

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Ella Burke

(Address) 223 S Collington Ave

15 Filed JAN 2 - 1923 OSCAR R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30th 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec 25, 1922, to Dec 30, 1922,

that I last saw her alive on Dec 29, 1922,

and that death occurred, on the date stated above, at 1.25 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~Home~~ ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo. H. Allen M. D.

1/11/23 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemy

DATE OF BURIAL Jan 2 1923

20 UNDERTAKER J J Moran

ADDRESS 300 E Baltimore

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70650

CERTIFICATE OF DEATH.

129 D70650

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home-Infirmary ST., 166 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ROBERT WATSON ANDERSON

(a) RESIDENCE No. 1216-W-Lanvale-St. ST., 16 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 62 yrs. 9 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Belle Mitchell Anderson

6 DATE OF BIRTH (month, day, and year) March-27-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	9	4	

8 OCCUPATION OF DECEASED 166

(a) Trade, profession or particular kind of work Traveling Salesman for

(b) General nature of industry, business, or establishment in which employed (or employer) The G. Washington Coffee Refining Co., N. Y.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Albemarle Co., Virginia

PARENTS

10 NAME OF FATHER James Nelson Anderson

11 BIRTHPLACE OF FATHER (city or town) Nelson Co., (State or country) Virginia

12 MAIDEN NAME OF MOTHER Henrietta Watson

13 BIRTHPLACE OF MOTHER (city or town) Nelson Co (State or country) Virginia

14 Informant Mrs. Belle M. Anderson (wife)
(Address) 1216-W-Lanvale-St., City

15 Filed JAN 2 - 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/25, 1922, to 1/1, 1923.

that I last saw him alive on 1/1, 1923,

and that death occurred, on the date stated above, at 1.50 p m.

The CAUSE OF DEATH* was as follows:

Uremia
Chronic Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Methods

(Signed) Geo. R. Coulson, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: WESTERN CEMETERY — DATE OF BURIAL: JAN-3-23, 19

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70651 CERTIFICATE OF DEATH. 31 D70651

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. #4512-Penhurst-Av. ST., 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stella Middleton Lloyd.

(a) RESIDENCE NO. #4512-Penhurst-Av. ST., 28 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? 24 yrs. 5 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Elmer Lloyd.

6 DATE OF BIRTH (month, day, and year) July-20-1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER William F. Middleton.

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A.Co., Maryland.

12 MAIDEN NAME OF MOTHER Stella M. Fort.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sandusky Ohio.

14 Informant Mr. R. E. Lloyd, (husband)
(Address) 4512-Penhurst-Ave City.

15 JAN 2-1923 ROBERT H. KRAUTER, Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT I... mation should be carefully supplied. AGE should be stated EXACTL... CAUSE OF DEATH in plain terms, so that it may be properly classified. ...S should state ...ement of OCCUPA- TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12. 31. 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 30 .1920. to Dec. 31, .1922. that I last saw h.. alive on Dec. 30 .1922 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? don't know

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum and Bacilli

(Signed) Martin F. Sloan M. D.

1. 1., 1923 (Address) 414 Professional Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
WOODLAWN CEMETERY	Jan-2-23
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODER, Successor)	ADDRESS 108 W. NORTH AVE

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70652

CERTIFICATE OF DEATH.

113 D70652

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Becks Lane ST., 20 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Berry

(a) RESIDENCE NO. 1303 Becks Lane ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 19 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 12 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Walter Berry

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elsie Matthew

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Elsie Matthew
(Address) 1303 Becks Lane.

15 Filed JAN 2 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/31/ 192 2

17 I HEREBY CERTIFY, That I attended deceased from 12/31/22 19 ..... to 12/31/22 19 .....

that I last saw h e alive on 12/31/22 19 .....

and that death occurred, on the date stated above, at 8 a.m. P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition (Cause)
Infantile Colitis (History)

(duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) —
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? History

(Signed) Bernard J Fury M. D.

1/1/23 19 (Address) 710 W. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem, DATE OF BURIAL Jan 2 1923

20 UNDERTAKER John J Boyce & Son ADDRESS 901 Hollins St
Jeff J Cowan

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D70653

D70653

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery and Childs Hospt ST., 70 WARD)

2-FULL NAME Bertha Parsons

(a) RESIDENCE NO. 2000 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	infant.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 3, 21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER George W. Parsons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Lelia Lyssun

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Lelia Parsons (Address) Frederick Ave

15 Filed JAN 2 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1922, to Jan 1, 1923, that I last saw h alive on Jan 1, 1923, and that death occurred, on the date stated above, at 5 20 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 702 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL Jan 2 1923

20 UNDERTAKER George E. Smith ADDRESS 1532 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cancer

Spec.—1-10-21—M&T—1500 Blks.

D70654

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D70654

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 26 WARD)

2-FULL NAME Christian Switger (Schweiker)

(a) RESIDENCE NO. None ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 27th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Swigart

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Lang

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Sallie Schmidt (Address) 407 N. Bethel St.

15 Filed JAN 2-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1922, to Dec. 31, 1922, that I last saw him alive on Dec. 31, 1922, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Clyde O'Neill M. D.

12-31, 19 22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Jan. 2, 1923
20 UNDERTAKER	ADDRESS
Philip Herwig	2611 Eastern Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002 D70655

D70655

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1002 S. Eutaw Street. St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Genevieve Sanders. (C). 2 -- 24.

(Residence in Baltimore: No. 1002 S. Eutaw Street. St.; yrs. ----- mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	Colored.	Single.

6-DATE OF BIRTH, October 7, 1922. (Month) (Day) (Year)

7-AGE. --- yrs. 2 mos. 24 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Lee Hunt. (C).

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Alice Mason. (C).

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Hunt. (C). (mother).

(Address) 1002 S. Eutaw Street.

15- Filed JAN 2-1923 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 31st, 1922. (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said decedent came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Jan. 1, 192 3. (Address) 1617 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Laurel Ct. DATE OF BURIAL. Jan 2, 1923

20-UNDERTAKER. J. L. Brown & Son ADDRESS 1011 W. Mary

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70656 32 D70656

CERTIFICATE OF DEATH.

D70656
1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Day Dress Hospital ST., 17 WARD)

2-FULL NAME Albert Wallace

(a) RESIDENCE NO. 805 Hanover ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mechanicsville Glass Co

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hosp. Records
(Address)

15 Filed JAN 2 - 1923 ROBERT R. KRAUTER, Burial Permit Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-26 1922 to 12-30 1922, that I last saw h[illegible] alive on 12-30 1922 and that death occurred, on the date stated above, at 4.45 p m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Tuberculous of Mediastinal Tuberculous glands (duration) 11 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

1/1, 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkers Creek Md Calvert Co	Jan 2 1923
20 UNDERTAKER	ADDRESS
J. A. Brown	108 W Mary St
6 Route 73 E.A. Lyons Sons Calvert Co. Md	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70657

CERTIFICATE OF DEATH.

31 D70657

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Garrett

(a) RESIDENCE No. 709 Tessier st. ST., WARD

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Years~~ Unknown Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not stated

6 DATE OF BIRTH (month, day, and year): 1893 - Aug. 13

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown General

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Chas. Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Eliza Booth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records

(Address): M.T.H.

15 Filed JAN 2-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 31, 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1922, to Dec. 31, 1922, that I last saw h. im alive on Dec. 31, 1922, and that death occurred, on the date stated above, at 6.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Alpheus O'Neill, M. D.

1-1-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel

DATE OF BURIAL: 1/3 1923

20 UNDERTAKER: Samuel Hemsley

ADDRESS 838 N Bdle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70658

CERTIFICATE OF DEATH.

100-001 D70658

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Oxford St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Ludonia Johnson

(Residence in Baltimore: No. 508 Oxford St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word.) Single

6-DATE OF BIRTH, ~~1901~~ July 11, 1921
(Month) (Day) (Year)

7-AGE, 1 yrs. 4 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) 00

9-BIRTHPLACE, (State or Country). Baltimore City

PARENTS.

10-NAME OF FATHER, Chas Johnson

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Mary Fuller

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Johnson

(Address) 508 Oxford St

15-

Filed JAN 2 - 1923 ROBERT R. KRAUTER, Register.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Dec 30th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 19th 1922, to Dec 30th 1922, that I saw h[er] alive on Dec 19th 1922, and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) 5 yrs. 1 mos. ds.

(Signed) A. Lee Lobe M. D.

1/1/, 1923. (Address) 522 Mosher

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yr. ....mos. ....ds. In the State ....yr. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Mt Auburn

DATE OF BURIAL, 1/2, 1923

20-UNDERTAKER Samuel Bensley

ADDRESS 1325 Eutaw St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D70659 HEALTH DEPARTMENT—CITY OF BALTIMORE D70659

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3206 Fait ave ST., 7th WARD)

2-FULL NAME Catharine Wiessner

(a) RESIDENCE NO. 3206 Fait ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jos. Wiessner

6 DATE OF BIRTH (month, day, and year): 31 Oct. 1855

7 AGE — Years: 67 — Months: 2 — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Thomas Alsch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Cath. Zaeber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna Schoegel

(Address) 3206 Fait ave.

15 JAN 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 30 19 22

17 I HEREBY CERTIFY, That I attended deceased from July 8, 19 22, to Dec 30, 19 22,

that I last saw h[illegible] alive on Dec 30, 19 22

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William [illegible] M. D.

19 23 (Address) 801 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem — DATE OF BURIAL: Jan 3 1923

20 UNDERTAKER: Jos J. Herr — ADDRESS: 153 N. Luzerne

IMPORTANT: WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70660

CERTIFICATE OF DEATH.

D70660

1-PLACE OF DEATH Univerity Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. ST.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Ford

(a) RESIDENCE. No. 328 East St. Frederick Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 4 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	x	x	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer) 0'10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md.

PARENTS

10 NAME OF FATHER Fred Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maggie Chambers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mother
(Address) 328 East St Frederick

15 Filed JAN 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30 1922

17 I HEREBY CERTIFY, That I attended deceased from 12-24- , 1922, to 12-30 , 1922 that I last saw h[illegible] alive on Dec-30 , 1922 and that death occurred, on the date stated above, at 4 [illegible] m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

ow

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) General Peritonitis c

Appendicitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1311 Druid Hill Ave

Did an operation precede death? Yes Date of 12-30-22

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Kenneth B. Jones M. D.

, 19 (Address) University Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 1 - 1923
20 UNDERTAKER	ADDRESS
Daniel Easton	Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Acute Gonorrhea
Due to Gonococcus Infection

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Admitted with acute pelvic peritonitis. Developed later Septicemia, Operation was done, for the relief of her peritonitis but patient developed a bronchial pneumonia which caused her death

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70661

CERTIFICATE OF DEATH.

57 D70661

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1405 William St.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vida Blanch Armiger

(a) RESIDENCE. No. 1405 William ST., 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer Armiger

6 DATE OF BIRTH (month, day, and year) 7.23.1887

7 AGE 35 Years 5 Months 7 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At House

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER George Orem

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md County

12 MAIDEN NAME OF MOTHER Mrs Louise Keis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs Louise Orem (Mother)

(Address) 1405 William St.

15 Filed JAN 2-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12.30 1922

17 I HEREBY CERTIFY, That I attended deceased from 12.10, 1922, to 12.30, 1922, that I last saw h[illegible] alive on 12.30, 1922, and that death occurred, on the date stated above, at 9.10. A m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) acute myocarditis

(duration) ..... yrs. 15 hours ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. F. Durlington, M. D.

, 19 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

DATE OF BURIAL: 1/2 1923

20 UNDERTAKER: I. Frew McCully

ADDRESS: 130 E. Fort

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Recurrent attacks of Rheumatic Fever

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70662

D70662

CERTIFICATE OF DEATH

188-002

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 239 St Joseph Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Chase

(Residence in Baltimore: No. 2396 Amity St. 11 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) 1871 (Year)

7-AGE, 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Driver
(b) General nature of industry, business, or establishment in which employed (or employer) Dr

9-BIRTHPLACE, (State or Country). North Carolina

PARENTS.

10-NAME OF FATHER, John Chase

11-BIRTHPLACE OF FATHER, (State or Country) N. Carolina

12-MAIDEN NAME OF MOTHER, ——

13-BIRTHPLACE OF MOTHER, (State or Country) N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Chase

(Address) 239 N. Amity St.

15- Filed JAN 2 - 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 30 (Month) (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures

Dr. Dor acc.

(Duration) ..... yrs. ..... mos. 5 hs. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm Clinton Blake M.D.
(Coroner.)

(Address) 143 N Bond

*State the Disease Causing Death, or, in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, June 3 1923

20-UNDERTAKER, Brown Leland & Schroder ADDRESS 1170 N

If any of the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70663

CERTIFICATE OF DEATH.

90

REGISTERED No. D70663

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 Schroeder ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Harris

(a) RESIDENCE. No. 308 Schroeder ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. X mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or, WIFE of): Abraham Harris

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: about 78 Years: — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Rockhall Maryland

PARENTS

10 NAME OF FATHER: Samuel Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rockhall Maryland

12 MAIDEN NAME OF MOTHER: Margaretta Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Rockhall Maryland

14 Informant (Address): Perry W. Elwell Washingtonville, Md.

15 Filed JAN 2 — 1923 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): December 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1922, to December 30 1922 that I last saw h alive on December 29, 1922 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Rockhall, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? physical findings and S-4 reactions

(Signed) John E. F. Campbell, M. D.

, 19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Jan 2 19 23

20 UNDERTAKER: Brown & Buckland — ADDRESS 1140 W. Schroeder St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70664

CERTIFICATE OF DEATH.

57 D70664

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4130 Pimlico Road ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Carnes

(a) RESIDENCE. No. 4130 Pimlico Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 15-1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	~~10~~ 1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Delivered Papers

(b) General nature of industry, business, or establishment in which employed (or employer) Newspaper

(c) Name of employer Chas. North

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Lawrence Carnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Marie Malone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Alex Godwin

(Address) 4130 Pimlico Rd.

15 Filed , 19

JAN 2-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 19 22

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 19 22, to Dec. 29, 19 22,

that I last saw him alive on Dec. 29, 19 22,

and that death occurred, on the date stated above, at Dec. 30 2 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis 2 Weeks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No Urinalysis

What test confirmed diagnosis?

(Signed) H. R. Johnson, M. D.

Jan 2. 19 22 (Address) 3928 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Jan 2. 1922

20 UNDERTAKER: Isaac S. Lyles — ADDRESS: 1210 W. Lanvale St.

Dr E

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70665

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70665

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 S. Collington Ave ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Friedman

(a) RESIDENCE No. 107 S Collington Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 10 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Friedman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Baltimore St.

Filed JAN 2 - 1923, 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1922, to Jan 2, 1923, that I last saw him alive on Jan 1, 1923, and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No Clinical

What test confirmed diagnosis? .....

(Signed) Wm Barlin, M. D.

1/2, 1923 (Address) 240 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Russdale

DATE OF BURIAL Jan. 2 1923

20 UNDERTAKER Jack Lewis, 1439 E Balto

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

yetter

40

D70666

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) St. Agnes Hospital (St.) ..... (WARD) 40

2-FULL NAME Mrs Fanny Yettaw

(a) RESIDENCE No. 338 S. Augusta Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, ~~(write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Yettaw

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47 Yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): York Pa.

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: William Yettaw

(Address) 338 S. Augusta Ave

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

JAN 2 - 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-30 1922

17 I HEREBY CERTIFY. That I attended deceased from 12-27, 1922, to 12-30, 1922, that I last saw her alive on 12-30, 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uterine Fibromyomata

Chr. Pelvic Inflam. Disease (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 12/20/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Starper, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 2 1923

20 UNDERTAKER: Harry H. Weitzel — ADDRESS: 1531 W. Lombard

IMPORTANT, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can bo known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) tho nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may bo entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough: Chronic valvular heart disease: Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mero symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Salpingitis of
Gonococcic origin

D70667

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70667

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE, (No. 2118 Cambridge St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Leyasman

(Residence in Baltimore: No. 2118 Cambridge St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Unknown (Month) (Day) 10 (Year) 1855

7-AGE: About 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15- JAN 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 28 (Month) (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. 9 or 10 mos. ds.

CONTRIBUTORY (Secondary) Cause yrs. mos. ds.

(Signed) Thos. B. Hinton M. D. (Coroner.)

Jan 2 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Balto. Md.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery DATE OF BURIAL, 1/2/1 1923

20-UNDERTAKER, George J. Ruth ADDRESS 1735 Harford Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70668

D70668

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Norton.

(a) RESIDENCE NO. 1834 Brent St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Norton.

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor.

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Patrick Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Boylan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Minnie Norton 834 Brent St

15 JAN 2-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1922, to Jan 1, 1923, that I last saw h in alive on Jan 1, 1923 and that death occurred, on the date stated above, at 8:20 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos 4. ds.

CONTRIBUTORY (Secondary) Cardiac Failure.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Signs & Symp.

What test confirmed diagnosis?

(Signed) V. J. Bourgeois, M. D.

, 19 (Address) St Mary's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Catholic Cem. DATE OF BURIAL Jan. 4 1923

20 UNDERTAKER Martin Tracy & Son ADDRESS 1837 W 7th

mad 0970

CARE FULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70669 X 90 D70669

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 E. North ave. WARD 12)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas F. Callahan (Sr)

(Residence in Baltimore: No. 301 E. North ave. yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, — — 1854
(Month) (Day) (Year)

7-AGE, 68 — —
yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired 186
(b) General nature of industry, business, or establishment in which employed (or employer) Canning factory

9-BIRTHPLACE, (State or Country), U.S.A.

PARENTS.

10-NAME OF FATHER, Thos Callahan

11-BIRTHPLACE OF FATHER (State or Country), Ire

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), U.S.A.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Callahan

(Address) 1534 Carlton ave

15-

Filed JAN 2 - 1923, 191

ROBERT R. KRAUTER, Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 1 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1923, to Jan 1 1923, that I saw him alive on Jan 1 10 A.M. 1923, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Hypertrophy Prostate

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(Duration) yrs. mos. 1 ds.

(Signed) Curtis Smith M. D.

Jan 1, 1923. (Address) 817 Park ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem

DATE OF BURIAL, 1 2, 1923

20-UNDERTAKER F. C. Mudrow

ADDRESS, 9 Light St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERMANENT RECORD

D70670

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70670

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Hanover & Cromwell Sts. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas P. Schaefer.

21 -- 6 -- 20 -

(Residence in Baltimore: No. 1324 Andre St. St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH, June 11, 1901.
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
21 yrs. 6 mos. 20 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Longshoreman
(b) General natnre of Industry, business, or establishment in which employed (or employer): B & O R.R.Co.

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, John A. Schaefer.

11-BIRTHPLACE OF FATHER, (State or Country). Philadelphia Pa.

12-MAIDEN NAME OF MOTHER, Mary A. Malone.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Schaefer. (mother).

(Address) 1324 Andre Street.

15-JAN 2-1923 Filed 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 31st, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull, laceration of brain
broduced while riding in automobile
recklessly driven into telephone bole
Homicide. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Jan. 1, 1923. (Address) 1017 S. Charles st.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Cross Cem. Hall Rd. DATE OF BURIAL, Jan. 3, 1923

20-UNDERTAKER, Margaret G. Flynn ADDRESS 1122 Light St.

D70671 D70671

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1922

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Hanover & Cromwell Sts. St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W.E.Mitchell.

(Residence in Baltimore: No. 418 N.Stricker St. St.; 29 yrs., 6 mos., 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH, June 21st. 1893.
(Month) (Day) (Year)

7-AGE. 29 yrs. 6 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fish Dealer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, John H.Mitchell.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER, Alice Wheeler.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John H.Mitchell.(father).
(Address) 418 N.Stricker St.

15- Filed JAN 2-1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 31st. 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull, laceration of brain produced while riding in automobile recklessly driven into telephone pole Homicide. (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ..... (Duration) ....yrs....mos....ds.

(Signed) H. M. Reinhardt M.D. (Coroner.)

Jan 1, 1923. (Address) 1017 N. Charles st.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Jan. 2 1923

20-UNDERTAKER, Margaret G. Flynn ADDRESS 1422 Light St.

Said CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D70672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1992 D70672

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hanover & Cromwell Sts. St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph H. Griffith.

36 ------- 18.

(Residence in Baltimore: No. 4 W. Virginia Ave. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Divorced.

6-DATE OF BIRTH. December 13, 1886.
(Month) (Day) (Year)

7-AGE. 36 yrs. --- mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pipe fitter.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Joshua O Griffith.

11-BIRTHPLACE OF FATHER, (State or Country). A.A.Co. Md.

12-MAIDEN NAME OF MOTHER. Agnes Norton.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joshua O. Griffith. (father).

(Address) 4 W. Virginia Ave.

15- Filed JAN 2-1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 31st, 1922.
(Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest & autopsy (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull, laceration of brain produced while riding in automobile recklessly driven into telephone pole

Homicide. (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Wm. R. Leuhart M. D.
(Coroner.)

Jan. 1, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cem. DATE OF BURIAL. Jan. 3 192

20-UNDERTAKER. Margaret G. Flynn ADDRESS 1422 Light St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should ... supplied.

D70673 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 D70673

CERTIFICATE OF DEATH.

1-PLACE OF DEATH South Baltimore Registered No. C.....

City of BALTIMORE: (No. General Hospital. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Argus Geoghegan.

(Residence in Baltimore: No. 47 E. Cross St. St.; yrs. 43 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Widower.

6-DATE OF BIRTH. December 7, 1875.
(Month) (Day) (Year)

7-AGE. 48 yrs. -- mos. 22 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Produce dealer.
(b) General nature of industry, business, or establishment in which employed (or employer): 645

9-BIRTHPLACE, (State or Country). Dorchester Co. Md.

PARENTS.

10-NAME OF FATHER. William Geoghehan.

11-BIRTHPLACE OF FATHER, (State or Country). Dorchester Co. Md.

12-MAIDEN NAME OF MOTHER. Susan Barnes.

13-BIRTHPLACE OF MOTHER, (State or Country). Dorchester Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elsie Geoghegan. (niece).
(Address) 764 W. Hamburg Street

15- Filed JAN 2 - 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 29th, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of an Cortic Aneurism.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto K. Reinhardt M. D.
(Coroner)

Jan. 1, 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Light and Cross Sts. December 29th. 1922.

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL. Cedar Hill Cem. DATE OF BURIAL. Jan. 2, 1923

20-UNDERTAKER. Margaret E. Flynn ADDRESS 422 Light St.

Please write information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70674 45 D70674

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1437 Towson ST. 24 WARD (FRANK)

2-FULL NAME Nicholas A. Frank

(a) RESIDENCE NO. 1437 Towson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 2 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bridget Frank

6 DATE OF BIRTH (month, day, and year) March 5 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	40	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Co., Md.
(State or country)

PARENTS

10 NAME OF FATHER William W. Frank

11 BIRTHPLACE OF FATHER (city or town) Balto. Co., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Laura Kolbe

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country) Md.

14 Informant Bridget Frank
(Address) 1437 Towson St.

15 Filed JAN 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-1- 1923

17 I HEREBY CERTIFY, That I attended deceased from 9-1-22, 19..., to 1-1-23, 19...,
that I last saw him alive on 1-1-23, 19...,
and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid Flexure of Colon.
(duration) dont know yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 12-5-22.

Was there an autopsy? no.

What test confirmed diagnosis? Examination of Tumor at time of Operation

(Signed) J Rowland Norris M. D.

1-1-23 19 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Jan. 4 1923

20 UNDERTAKER M. L. Flynn

ADDRESS 1422 Light St.

IMPORTANT SUBJECTS TO BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70675

CERTIFICATE OF DEATH

129

D70675

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ... ST., ... WARD)

2-FULL NAME Andrew Bruce

(a) RESIDENCE NO. Centerview Rd. ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE — Years: 65 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Centerview Md

PARENTS

10 NAME OF FATHER Centerview

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Bay View Hospital Balto, Md

15 Filed JAN 2 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1922 to Dec 31, 1922

that I last saw him alive on Dec 30 1922

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Chronic Pyelonephritis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Centerview

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) N. Goldsmith M. D.

1/2/ 1922 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holt Civil Cemetery

DATE OF BURIAL Jan 4 1922

20 UNDERTAKER W. M. Routson

ADDRESS 2238 N North

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70676

CERTIFICATE OF DEATH.

129 D70676

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1830 Orleans ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Dulin

(a) RESIDENCE NO. 1830 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos O Dulin

6 DATE OF BIRTH (month, day, and year) Jan 2-1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Herford Co N C

PARENTS

10 NAME OF FATHER Lewis Brett

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Mrs Ario L Bowen

(Address) 1830 Orleans St

15 Filed JAN 2-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 11, 1922, to Dec, 19....

that I last saw h[illegible] alive on Dec 30, 1922,

and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an atttopsy? no

What test confirmed diagnosis?

(Signed) Geo L McCaffrey, M. D.

Jan 1, 1923 (Address) 2320 Marlyn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Jan 3 1923

20 UNDERTAKER John Dellerich

ADDRESS 2008 Orleans

Fill in should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70677 — CERTIFICATE OF DEATH. — 129 — D70677

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 2011 Orleans St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. Brutsbach Jr.

(Residence in Baltimore: No. 2011 Orleans. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Aug. (Month) 5 (Day) 1883 (Year)

7-AGE.	If LESS than 1 day,
39 yrs. 4 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Plumber
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Fred Brutsbach

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Hinkel

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Brutsbach

(Address) 2011 Orleans St

15- Filed JAN 2 - 1923 ROBERT R. KRAUTER, Registrar.

Social Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec. (Month) 31 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Par. Nephritis

Duration yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

Duration yrs. mos. ds.

(Signed) Geo. Clinton Radcliff M.D. (Coroner.)

Jan. 1 1923 (Address) 417 N. Bond

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cem	Jan 4 1923

20-UNDERTAKER.	ADDRESS
John Ulrich	200 Orleans

State CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate. Supplied. AGE should be stated EXACTLY. PHYSICIANS should at it may be properly classified. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Bks.

D70678 HEALTH DEPARTMENT—CITY OF BALTIMORE

D70678

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1327 Cookson St. ST. 24 WARD)

2-FULL NAME Christian Hoffman

(a) RESIDENCE NO. 1327 Cookson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hoffman

6 DATE OF BIRTH (month, day, and year) July 20 1857

7 AGE Years 65 Months 5 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Repairer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Leonard Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary Hoffman

(Address) 1327 Cookson St

15 Filed JAN 2 - 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1922, to Dec 31, 1922,

that I last saw him alive on Dec 31, 1922,

and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

What was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. F. Stevens M. D.

1.2., 1923 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Jan 3 1923

20 UNDERTAKER John Zellerich

ADDRESS 2007 Orleans

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70679

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D70679

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 413 N. Lakewood ST.; 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Henderson

(a) RESIDENCE. No. 413 N. Lakewood ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Nov 19th 1922

7 AGE — Years: — Months: 1 — Days: 14 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Monroe J. Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary E. Peary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant (Address): Monroe J. Henderson 413 N. Lakewood ave.

15 Filed JAN 2 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1922, to Jan. 1, 1923. that I last saw him alive on Dec 30, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Hearn M. D.

1, 1923 (Address) 2600 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: 1/4 1923

20 UNDERTAKER: J. A. Moran ADDRESS 3000 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. ... AGE should be stated EXACTLY. PHYSICIANS should state ... item of information

Liebmann

D70680 HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001 D70680

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1612 N. Washington St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moritz Liebmann

(Residence in Baltimore: No. 1612 N. Washington St. St.; yrs. 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH, Aug 12 (Month) (Day) 1857 (Year)

7-AGE, 65 yrs. — mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer), Manufacturer

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER, (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss C. Liebmann

(Address) 1612 N. Washington St.

15- Filed JAN 2 - 1923 192.... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 31 (Month) (Day) 192 2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ill. Gas Accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) As Physician

(Duration) yrs. mos. ds.

(Signed) Geo. Claude Bladet M. D.

(Coroner.)

Jan 1 1923 (Address) 1413 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Co. DATE OF BURIAL, Jan. 3 192 3

20-UNDERTAKER, Chas. Johnson & Son ADDRESS 1413 N. Broadway

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should be stated EXACTLY.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D70681
1 PLACE OF DEATH

CERTIFICATE OF DEATH

129 D70681
REGISTERED No. C

CITY OF BALTIMORE (No. 705 Gorsuch Ave WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary E. Frey

(Residence in Baltimore: No. 705 Gorsuch Ave St.: yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed
6 DATE OF BIRTH: July (Month) 22 (Day), 1847 (Year)
7 AGE: 75 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
9 BIRTHPLACE (State or country): Balto Md

PARENTS
10 NAME OF FATHER: Charles McComas
11 BIRTHPLACE OF FATHER (State or country): Balto Md
12 MAIDEN NAME OF MOTHER: Susan Mosford
13 BIRTHPLACE OF MOTHER (State or country): Balto Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Annie McComas
(Address) 705 Gorsuch Ave

15 Filed JAN 2 - 1923, 191 ROBERT R. KRAUTER Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 2 (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1922, to Jan 2, 1923, that I saw h[illegible] alive on Jan 1, 1923, and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

about
(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) —
(Duration) yrs. mos. ds.

(Signed) H. G. Ornduss M. D.
Jan 2, 1923 (Address) 634 Gorsuch Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mountain Christian Church — DATE OF BURIAL: 1/4/23

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D70682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D70682

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2629 Hampden ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel Martin Whiteford

(Residence in Baltimore: No. 2639 Hampden Ave St.; 8 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 22, 1850
(Month) (Day) (Year)

7-AGE 72 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Wm Whiteford

11-BIRTHPLACE OF FATHER (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie L. Whiteford

(Address) 2629 Hampden

15-

Filed JAN 2 - 1923, 191... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 1, 1923
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 31 1922, to Jan 1 1923, that I saw h alive on Dec 31 1922, and that death occurred, on the date stated above, at 12.01 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(Duration) yrs. 8 mos. ds.

(Signed) Lucas Stevens M. D.

Jan 1, 1923 (Address) 1438 Hampden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet

DATE OF BURIAL, 1/3, 1923

20-UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

important. See instructions on back of certificate.

Or More Should Be,

Spec.—1-10-21—M&T—1500 Bks.

D70683 HEALTH DEPARTMENT—CITY OF BALTIMORE D70683

CERTIFICATE OF DEATH. 58-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 Bouldin St ST No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hoffman

(a) RESIDENCE NO. 313 Bouldin St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Schultz.

6 DATE OF BIRTH (month, day, and year) Oct 26 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Steel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Anna Hoffman

(Address) 313 Bouldin St

15 Filed JAN 2-1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) DEC. 31 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1. 1922. to Dec 31 1922, that I last saw h alive on Dec 31 1922, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Contusion Anemia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Hypertrophic Cirrhosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgical Pathological Exam

(Signed) [illegible], M. D.

, 19 (Address) 3015 Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dale Cem DATE OF BURIAL Jan 3 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state items of information carefully supplied.

Spec.—1-10-21—M&T—1500 Bks.

D70684 HEALTH DEPARTMENT—CITY OF BALTIMORE D70684

CERTIFICATE OF DEATH 4 X 90

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 6210 Wilday Ave ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary - E - Cranston

(a) RESIDENCE NO. 6210 Wilday ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12 - 29 - 1845

7 AGE Years 77 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Alexander Cranston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Sarah Mullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Dallie Hoffmann

(Address) 2321 Callow Ave

15 Filed JAN 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 1 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1922, to Jan - 1 -, 1923, that I last saw h alive on Dec. 31 -, 1923, and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

Several years.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Koerber, M. D.

Jan 1 - 1923 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dungville Md. DATE OF BURIAL 1/3 1923

20 UNDERTAKER Wm Cook ADDRESS Sole Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70685 HEALTH DEPARTMENT—CITY OF BALTIMORE D70685

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Univ. Hospital ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Bailey

(a) RESIDENCE. No. 2708 Penn-Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Stephen Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Addie Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Hospital Records (Address)

15 Filed JAN 2 1923, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 19 ✓✓

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 19 ✓✓ to Dec 31, 19 ✓✓, that I last saw her alive on Dec 31, 19 ✓✓, and that death occurred, on the date stated above, at 7:00 A. m.

The CAUSE OF DEATH* was as follows:

Chronic pelvic inflammatory disease

not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lung abscess

(duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death? Bay View Hospital

Did an operation precede death? yes Date of Oct. 6, 19 ✓✓

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy, X-Ray & clinical findings

(Signed) George C. Hatley, M. D.

Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 3 192 2
20 UNDERTAKER James H. Dennis	ADDRESS 213 Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gonococcus Infection

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70686 CERTIFICATE OF DEATH. 100-001 D70686

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 565 Mosher ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah C. Ebb

(a) RESIDENCE. No. 565 Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ×

6 DATE OF BIRTH (month, day, and year) Feb 5, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Catonsville Md

PARENTS

10 NAME OF FATHER Samuel A. Ebb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Nancy B. Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md.

14 Informant (Address) Mary E. Hawkins 565 Mosher St

15 Filed JAN 2 1923, 19 ROBERT H. KNAUER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1922, to Dec. 31, 1922, that I last saw h[illegible] alive on Dec. 31, 1922, and that death occurred, on the date stated above, at 12.35 P. m.

The CAUSE OF DEATH* was as follows:

Tubercle Bronchitis (Non-Tubercular)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) William A. Stamm, M. D.

, 19 (Address) 1200 Penn Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Star Cemetery	Jan 4 1923

20 UNDERTAKER James H. Dennis ADDRESS 803 Gittman

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 10-79 (W. C. Co.) 1000 Bks.

D70687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 D70687

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; No. 1327 Bolton St ST.: 11 WARD)

2-FULL NAME Isham Randolph Page

(a) RESIDENCE. No. 1327 Bolton St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If ~~married~~, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) June 3rd 1834

7 AGE: Years 88 Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: William Nelson Page

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Jennie Randolph

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Frances M Page
(Address): 1327 Bolton St

15 Filed ..... 19 .....
Registrar

JAN 2 - 1923 ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1922, to Dec 31, 1922, that I last saw him alive on Dec. 31, 1922 and that death occurred, on the date stated above, at 2.00 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary): Heart failure

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Jno A Kolb M. D.

19 (Address) 1025 Mad. ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. DATE OF BURIAL: Jan 3rd 1923

20 UNDERTAKER: Henry H Jenkins Sons Co ADDRESS: Eastwood Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-0-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70688 D70688

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1546 Woodyear ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edward Delaney

(a) RESIDENCE. No. 1546 Woodyear ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Betty Delaney

6 DATE OF BIRTH (month, day, and year) May 11, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	7	09	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Auto Washerette

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pamsville, Amelia Co. Va.

PARENTS

10 NAME OF FATHER George Delaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pamsville Amelia Co. Va

12 MAIDEN NAME OF MOTHER Sallie Booker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pamsville Amelia Co. Va.

14 Informant Betty Delaney (Address) 1546 Woodyear St

1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1922

17 I HEREBY CERTIFY, That I attended deceased from October 24, 1922 to Dec. 30 1922

that I last saw h alive on October 30 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronica

(duration) yrs. 6? mos. ds.

CONTRIBUTORY (Secondary) c

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical-Urinary

(Signed) William H. Wright M. D.

Jan 1 1923 (Address) 1209 Pressman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Amelia Court House Va.	Jan 3 1923
20 UNDERTAKER	ADDRESS
Thurders White	113 E. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70689

CERTIFICATE OF DEATH.

90 D70689

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2904 Huntingdon ave St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lola Mary Klinefelter

(Residence in Baltimore: No. 2904 Huntingdon ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... August ..... 27 ....., 1898
(Month) (Day) (Year)

7-AGE, ... 24 ..... yrs. .... 4 .... mos. .... 5 .... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Department Store

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, James J. Klinefelter

11-BIRTHPLACE OF FATHER (State or Country), York Co., Pa.

12-MAIDEN NAME OF MOTHER Rosa T. Schumaing

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James J Klinefelter

(Address) 2904 Huntingdon ave

15-

Filed ..... 191.....

Registrar.

2 - 1923 Robert ...

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January ..... 1 ....., 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1922, to Jan 1 1923, that I saw h er alive on Jan 1 1923, and that death occurred, on the date stated above, at 8.25 a. m.

The CAUSE OF DEATH* was as follows:

..... Chronic valv. heart disease .....

.....

..... (Duration) 1 yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

1/1, 1923 (Address) 2020 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	Jan 4 '23, 191...
20-UNDERTAKER	ADDRESS
A S Waisdl	2539 Falls Rd

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70690

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70690

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 444 W. Lakewood ave. ST.; 6 WARD)

2-FULL NAME Annie M. Hoffman.

(a) RESIDENCE. No. 444 W. Lakewood ave ST., 6 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 3 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Hoffman

6 DATE OF BIRTH (month, day, and year) Aug 31st 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	51	3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

57

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Traulk.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant George Hoffman (Husband)

(Address) 444 W. Lakewood ave.

15 Filed 2-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 30th 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 13 1921, to Dec 30 1922, that I last saw her alive on Dec 29 1922, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Herzog M. D.

Dec 31 1922 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Jan 3rd 1923

20 UNDERTAKER Lilly & Geier

ADDRESS 403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70691

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 S. East ave St.) 1 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Evans

(a) RESIDENCE. NO. 1008 S. East. ave 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 12-1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rolling Mill Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Cop Iron Mill

(c) Name of employer Eastern Rolling Mill

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Thomas J. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md

12 MAIDEN NAME OF MOTHER Mary E. Bryant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Thos. J. Evans (Father) (Address) 1008 S. East. Ave.

15 Filed 1923 Robert P. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1922, to Jan 1, 1923, that I last saw him alive on Jan 1, 1923, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M J McAvoy, M. D.

1/2 1923 (Address) 830 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 4th 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	400 S. Wolfe

Burial Permit Clerk.

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation should state TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70692

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70692

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 720 S. Linwood Ave ST., 1 WARD)

2-FULL NAME Robert St. Melton

(a) RESIDENCE NO. 720 S. Linwood Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma C. Melton

6 DATE OF BIRTH (month, day, and year) Aug. 13-1858.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass Caster

(b) General nature of industry, business, or establishment in which employed (or employer) Falls Tube Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Connecticut

PARENTS

10 NAME OF FATHER Robert Melton.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn.

12 MAIDEN NAME OF MOTHER Julia Pritchett.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn.

14 Informant Emma C. Melton. (Address) 720 S. Linwood Ave.

15 Filed Jan 5 1923 Robert P. Garrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec 8 1922 to Jan 1 1923.

that I last saw h— alive on Jan 1 1923.

and that death occurred, on the date stated above, at 3.15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage —

(duration) yrs. mos 23 ds.

CONTRIBUTORY (Secondary) Coma —

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) Jno A Bower, M. D.

, 19 (Address) 125 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Walkhill Cem. (Orange Co.) Newburg, N.Y. DATE OF BURIAL Jan. 5 1923

20 UNDERTAKER Lilly & Zeiler. ADDRESS 403 S. Wolfe St.

2 — 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D70693

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1774 Montpelier ST.: 9 WARD)

2-FULL NAME: Katharine A. Thumser.

(a) RESIDENCE. No. 1774 Montpelier ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George E. Thumser

6 DATE OF BIRTH (month, day, and year) May 25th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	7	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Bean.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Kate Kelly.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant George E. Thumser.
(Address) 1774 Montpelier St.

15 Filed 1923 Robert P. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1. 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1922, to Jan 1, 1923, that I last saw her alive on Jan 1, 1923, and that death occurred, on the date stated above, at 2. ., m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) F. X. Kinzey, M. D.

1/2, 1923 (Address) 2700 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Baltimore Cemetery Jan 3rd 1923

20 UNDERTAKER — ADDRESS

Mrs. Mrs. John H. Deufel & Son 801 N. Fayette St.

Burial Permit Clerk.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. Chester Wysowaty

D70694

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70694

CERTIFICATE OF DEATH.

100-001

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Shakespeare ST., V WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chester Wsowate

(a) RESIDENCE NO. 1628 Shakespeare ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. 2 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 25 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John wisawaty

11 BIRTHPLACE OF FATHER (city or town) (State or country) poland

12 MAIDEN NAME OF MOTHER Aleksandra Dobrzych

13 BIRTHPLACE OF MOTHER (city or town) (State or country) poland

14 Informant John wisawaty (Address) 1628 Shakespeare st

15 Filed JAN 2 — 1923 ROBERT R. KRAUTH Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1922, to Jan 2, 1923.

that I last saw him alive on Jan 1, 1923

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pneumonia (bronchial)

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) /

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) John H. Rehberger, M. D.

19 (Address) 1709 Aliceanna St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Jan 3 1923

20 UNDERTAKER John A Weber — ADDRESS 1803 Bank

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may bo indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"): *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. Tho contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pneumonia

Spec.—1-10-21—M&T—1500 Bks. Edward Struzynski ✓

D70695

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70695

CERTIFICATE OF DEATH.

100-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 S. Bond ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Struginski

(a) RESIDENCE No. 621 S. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 21 1922

7 AGE — Years — Months — Days: 11 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Czeslaw Struginski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Mary Posniatowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address) Czeslaw Struginski 621 S. Bond St.

15 Filed JAN 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 2, 1923,

that I last saw him alive on Jan 1, 1923,

and that death occurred, on the date stated above, at 1 35 a. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rehberger, M. D.

, 19 (Address) 1709 Alice Anna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: Jan 3 1923

20 UNDERTAKER: John M Weber — ADDRESS: 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70696

CERTIFICATE OF DEATH.

90 D70696

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1639 E Monument St. (WARD) 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lewis Brown

(a) RESIDENCE NO. 1639 E Monument St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Brown

6 DATE OF BIRTH (month, day, and year) Jan 1st 1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto Dry Docks 086

9 BIRTHPLACE (city or town) Harrisburg

(State or country) Pa

PARENTS

10 NAME OF FATHER John H. Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Kate Bowman

13 BIRTHPLACE OF MOTHER (city or town) Harrisburg

(State or country) Pa

14 Informant Mrs Virginia Joe Klein

(Address) 1675 Eutaw Pl Ave.

15 Filed JAN 2 - 1923, 19

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1st 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 30, 1922, to Jan 1, 1923.

that I last saw h. alive on Jan 1, 1923

and that death occurred, on the date stated above, at 17 05 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory Paralysis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. E. Hamer, M. D.

Jan 2, 1923 (Address) 1301 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 3rd 1923
20 UNDERTAKER Joseph B. Cole	ADDRESS 1003 N Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70697

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70697

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1111 Dukeland St. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie C. Dahl

(Residence in Baltimore: No. 1111 Dukeland St. St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. July 23" 1863
(Month) (Day) (Year)

7-AGE. 59 yrs. 5 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER. (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Charles W. Bell

(Address) 1629 N. Payson St.

15- Robert P. Harrison,

Filed 2-1923 192 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 31st 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Central Lymphosarcoma

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. ds.

(Signed) J. O. Hennessy, M. D.
(Coroner.)

Jan. 1 1923 (Address) 2302 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Lorraine Cem. DATE OF BURIAL. Jan 3" 1923

20-UNDERTAKER. Joseph L. B. Cook ADDRESS 1003 N. Dallas St

Is very important. See instructions on back of certificate. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Bks.

D70698

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70698

CERTIFICATE OF DEATH.

89

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 W. Lombard St. St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arminius Wills Totten

(a) RESIDENCE NO. 1410 W. Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn S. Totten

6 DATE OF BIRTH (month, day, and year) Aug. 28" 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of Industry, business, or establishment in which employed (or employer) 055

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mr. Greensboro North Carolina

PARENTS

10 NAME OF FATHER John Totten

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Fannie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Mrs. Evelyn Totten

(Address) 1410 W. Lombard St.

15 Filed 1-2, 1923, 19 Robert F. Carrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1" 19 23

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1, 19 22, to Jan. 1, 19 23

that I last saw h[illegible] alive on Jan. 1, 19 23

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 0 yrs. 2 mos 0 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Hypertension

(Duration) 3 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. H. Warner, M. D.

1/1, 19 23 (Address) 119 N. Carey St.

Noah H. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Jan 4 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Dallas St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70699

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70699

CERTIFICATE OF DEATH. X 129

1-PLACE OF DEATH Union Protestant Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. W. P. I. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank S. Borrick

(a) RESIDENCE NO. Columbus, Ohio ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. F. S. Borrick

6 DATE OF BIRTH (month, day, and year) Feb 17, 1866

7 AGE: Years 56 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manager in Corset

(b) General nature of industry, business, or establishment in which employed (or employer): Co

(c) Name of employer 045

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Edward Borrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Julia Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mrs F. S. Borrick

15 Filed , 19 Robert J. [illegible] Registrar

Burial Permit Clerk.

2 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1922, to Jan 7, 1923, that I last saw him alive on Jan 7, 1923, and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

uremia condition secondary to chronic nephritis

(duration) 10 yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (?) amyotrophic sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Lab.

(Signed) B. Newburger, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown Md. DATE OF BURIAL: Jan 3 1923

20 UNDERTAKER: Chas. E. Zoomack ADDRESS: 807 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should state TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70700

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D70700

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH The Hospital for the Women of Maryland

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 11 WARD)

2-FULL NAME Baby Lucas (Girl)

(a) RESIDENCE NO. 1305 Linden Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, 5 hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER William B. Lucas.

11 BIRTHPLACE OF FATHER (city or town) Charlestown
(State or country) West Virginia

12 MAIDEN NAME OF MOTHER Rebecca Nicholson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland.

14 Informant W. B. Lucas
(Address) 130 Linden Ave

15 Filed ....., 19 .... Robert F. Garrison, Registrar
Burial Permit Clerk.

2-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2, 1923.

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 ..., to Jan 2, 1923.

that I last saw her alive on Jan 2, 1923,

and that death occurred, on the date stated above, at 6:15 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No. What test confirmed diagnosis? Inspection

(Signed) Norman E. Tannenbaum M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL Jan 3 1923

20 UNDERTAKER Chas. S. Branch & Sons ADDRESS Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70701

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70701

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH The Hospital for the Women of Maryland. REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., 11 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lucas (Boy)

(a) RESIDENCE NO. 1305 Linden Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 2, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day 3 hrs. 55 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Wm. B. Lucas

11 BIRTHPLACE OF FATHER (city or town) Charlestown
(State or country) West Virginia

12 MAIDEN NAME OF MOTHER Rebecca Nicholson.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant C. B. Lucas
(Address) 30 Forrest Ave

15 Filed ..... 19 ..... Robert F. ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to Jan 2 .1923.

that I last saw him alive on Jan 2 .1923.

and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inspection

(Signed) Henrique E. Rennebaum M. D.

..... 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL Jan 3 1923

20 UNDERTAKER Chas. E. Franck — ADDRESS 1111 Madison Ave

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8 24 14—M. & T.—2000 lbs.

D70702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 99-002 D70702

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2556 Druid Hill Ave St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick A. Graebel

(Residence in Baltimore: No. 2556 Druid Hill ave St.; 72 yrs., 11 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Jan (Month) 6th (Day), 1850 (Year)

7-AGE, 72 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Manufacturing Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Geo. Graebel

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Sophia Kremodel

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Martha Graebel

(Address) 2556 Druid Hill Ave.

15-

Filed ....., 191.....

Robert F. Harrison, Registrar.

1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 1st (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 22nd 1922, to Jan 1st 1923, that I saw h.m alive on Jan 1st 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

..... (Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) 15 yrs. ....mos. ....ds.

(Signed) E. Magruder Gladden M. D.

Jan 1st, 1923 (Address) 900 N. Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Jan. 3, 1923

20-UNDERTAKER Chas. E. Evans & Son ADDRESS 1 W Madison

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

CAUSE AND DURATION OF OCCUPATION

Spec.—8-24-14—M. & T.—2000 Bks. (Prochoska) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70703 D70703

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 846 S. Bond ST.; 3 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Prochaska

(Residence in Baltimore: No. 846 S. Bond St.; 38 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... (Month) Nov (Day) 1 (Year)

7-AGE,	If LESS than 1 day,
38 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Day

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Frank Prochaska

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Anna Brown

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Centoni Prochaska

(Address) 846 S. Bond St

15-

Filed....., 191.....

ROBERT F. HARRISON
Registrar.

1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 30 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to Dec 30 1922, that I saw h... alive on Dec 30 1922, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Bronchitis

(Duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William H. Jones M. D.

Nov 1, 1923 (Address) 801 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Jan 3, 1923

20-UNDERTAKER H. A. Prochaska

ADDRESS 1916 Eastern Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70704 D70704

CERTIFICATE OF DEATH. 11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5922 Falls Road St. 27 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan R Hittabridle

(a) RESIDENCE. No. 5922 Falls Rd. St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Mar 23 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64.	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kansas Ill.

PARENTS

10 NAME OF FATHER Joseph J Hittabridle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co Md

12 MAIDEN NAME OF MOTHER Susan R DeLauder

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co (State or country) Maryland

14 Informant (Address) Mrs. Jennie E Sabers 5922 Falls Road

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 31 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1922, to Dec 31, 1922, that I last saw her alive on Dec 31, 1922, and that death occurred, on the date stated above, at 4. P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza — (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? — What test confirmed diagnosis? (Clinical)

(Signed) Dr A Sorensen, M. D.

, 19 (Address) 6 E Preston Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	Jan. 3 1923
20 UNDERTAKER	ADDRESS
Horace H. Burgee	1631 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70705

CERTIFICATE OF DEATH.

48 D70705

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 656 N. Fayett ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elijah F Powell.

(Residence in Baltimore: No. 656 N. Fayett St.; 7 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~, (*Write* the word.) Married

6-DATE OF BIRTH, Feb (Month) 13 (Day), 1857 (Year)

7-AGE, 65 yrs. 10 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer-
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Whittington Powell.

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Dryden-

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Frank Elliott

(Address) 656 N. Fayette St.

15- Robert F. Harrison,

Filed ....., 191..... Registrar.

2-1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 2 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12-25- 1922, to Jan 1 1923, that I saw h-- alive on Dec 31 1922 and that death occurred, on the date stated above, at 1.10 a m.

The CAUSE OF DEATH* was as follows:

General Debility

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Cancer- Face-

(Duration) 15 yrs. ....mos. ....ds.

(Signed) H. N. King- M. D.

1-2....., 1923 (Address) 651 W. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, FRIENDSHIP CEM PRINCESS ANN. MD

DATE OF BURIAL, 1/4....., 1923

20-UNDERTAKER ROBERT BROOKS & SON

ADDRESS CALHOUN HOLLINS ST

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

(Rothange)

D70706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70706

CERTIFICATE OF DEATH.

111-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Rothange

(a) RESIDENCE NO. 1204 Glyndon Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widr

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anita C Rothange

6 DATE OF BIRTH (month, day, and year): Sept 11 1878

7 AGE: Years 44; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Packer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore md

PARENTS

10 NAME OF FATHER: Conrad Rothange

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: E. Imerlach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Anita C Rothange

(Address): 1204 Glyndon Ave

15 Filed 1923 . 19 ROBERT J. GARRISON, Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1 — 1 — 1923

17

I HEREBY CERTIFY, That I attended deceased from 12-31-, 1922, to Jan 1, 1923, that I last saw him alive on December 31, 1922, and that death occurred, on the date stated above, at 0.35 A. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer.

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary): Hemorhages

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of June 20-22

Was there an autopsy? Yes. 1/1/23

What test confirmed diagnosis? Autopsy.

(Signed) Chas Wilbur Stewart M. D.

1/1/1923 (Address) 1738 E-28 st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — DATE OF BURIAL: 1-3 1923

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Lachman Hollins st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70707

Spec.—6-9-19—H. P. Co.—1000 Bks.

31 ✓ D70707

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 737 Dolphin ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Thompson

(a) RESIDENCE. NO. 734 Dolphin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Jas. Thompson

6 DATE OF BIRTH (month, day, and year): Sep. 6 1867

7 AGE — Years: 55 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Wm. R. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): Anne M. Fuld 734 Dolphin St

15 JAN 3 - 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 31 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14 1922 to Dec 31 1922

that I last saw her alive on Dec. 30 1922

and that death occurred, on the date stated above, at 12.07 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. unknown ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) David Weyman M. D.

Jan 2. 1923 (Address) 1006 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Jan 3 1923

20 UNDERTAKER: Robt. H. Lenhardt — ADDRESS 142

IMPORTANT. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70708

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70708

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 S. Chester St. ST., 2 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene M. Walstrum

(a) RESIDENCE NO. 120 S. Chester St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 23, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coder

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer U.S. Fidelity Co.

9 BIRTHPLACE (city or town) Balto. City

(State or country) Md.

PARENTS

10 NAME OF FATHER Peter J. Walstrum

11 BIRTHPLACE OF FATHER (city or town) Balto. City

(State or country) Md.

12 MAIDEN NAME OF MOTHER Marion Lewis

13 BIRTHPLACE OF MOTHER (city or town) Balto. City

(State or country) Md.

14 Informant Mrs. Marion Walstrum

(Address) 120 S. Chester St.

15 Filed JAN 3 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1922 to Jan 1, 1923, that I last saw her alive on Dec 31, 1922 and that death occurred, on the date stated above, at 4 a m

The CAUSE OF DEATH* was as follows:

Paralysis left side

Contrib. Gall Bladder (duration) 1 yrs. 2 mos 1 ds.

CONTRIBUTORY (Secondary)

Pleurisy (duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? / Date of /

Was there an autopsy? /

What test confirmed diagnosis? /

(Signed) W A B Sellman, M. D.

, 19 (Address) 5 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Jan. 3, 1923
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway

Spec.—1-10-21—M&T—1500 Blks.

D70709

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D70709

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2724 Hampden Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H Hoffmaster

(a) RESIDENCE NO. 2724 Hampden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Jennie C Hoffmaster

6 DATE OF BIRTH (month, day, and year) Feb 16 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	63	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shop hand

(b) General nature of industry, business, or establishment in which employed (or employer) R R

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Hoffmaster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jennie Hoffmaster

(Address) 2724 Hampden

15 Filed JAN 3 — 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Jan 1, 1923, that I last saw him alive on Jan 1, 1923, and that death occurred, on the date stated above, at 4.50 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Emmett E. Mayer, M. D.

1/3, 1923 (Address) 2438 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Jan 4 1923

20 UNDERTAKER Chenoweth & Son — ADDRESS Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70710

CERTIFICATE OF DEATH.

129 D70710

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Bay View Hosp ST., 5 WARD)

2-FULL NAME Emma Wells

(a) RESIDENCE NO. 432 W Fourth St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ala

PARENTS

10 NAME OF FATHER Jordan Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ala

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant ..... (Address) Hosp Record

15 Filed JAN 3 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-31-1922

17 I HEREBY CERTIFY, That I attended deceased from 12-7-, 1922, to 12-31-, 1922 that I last saw h~~e~~ alive on 12-31-, 1922 and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No What test confirmed diagnosis? Clinical Path

(Signed) Clyde Moneil M. D.

1/2/, 1923 (Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Springs-Alabama — DATE OF BURIAL Jan 3 1923

20 UNDERTAKER Daniel Easton — ADDRESS 916 Pa ave

DISEASE OR DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70711

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 D70711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Robert Garrett Hospital for Children REGISTERED NO.

CITY OF BALTIMORE: (No. 27 N. Carey ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Garnetta Elizabeth Abigill

(a) RESIDENCE No. 2107 Boyd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 26 1911

7 AGE Years 11 Months 4 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Joseph Thomas Abigill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Daisy Orlena Engle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Joseph Thomas Abigill (Address) 2107 Boyd St

15 JAN 3 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 2 1922

17

I HEREBY CERTIFY, That I attended deceased from May, 1920, to January 2, 1922, that I last saw her alive on January 2, 1922, and that death occurred, on the date stated above, at 4 00 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency and Dilatation

(duration) 2 yrs. 8 mos. ds. over

CONTRIBUTORY (Secondary) Bronchitis & Pulmonary Edema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. W. Clift, M. D.

1/2, 1923 (Address) Robt Garrett Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Jan 5 1923

20 UNDERTAKER Geo. H. Schwab ADDRESS 2101 Frdk Rd.

CAUSE OF DEATH should state plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D70712

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 Franklin Ave Overlea ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelia Rampley Turner

(a) RESIDENCE. NO. near Taylor Harford Co ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND~~ (or) WIFE of Langton James Calder Turner

6 DATE OF BIRTH (month, day, and year) Dec 24 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Madonna
(State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Robert Nelson Rampley

11 BIRTHPLACE OF FATHER (city or town) Madonna
(State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Frances Reed Mauld

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Harford Co Md

14 Informant Mrs Rockefus H Hoge
(Address) 110 Franklin Ave. Baltimore

15 JAN 3 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 31 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922, to Dec 31, 1922, that I last saw h[illegible] alive on Dec 31, 1922, and that death occurred, on the date stated above, at 6 10 P m.

The CAUSE OF DEATH* was as follows:

Right Hemiplegia
(Cerebral Hemorrhage)
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Right Hemiplegia
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

1/2, 1923 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St James Cem, Monkton	Jan 3 1923
20 UNDERTAKER	ADDRESS
E J Kurtz & Son	Parrettsville Md

THIS IS VERY IMPORTANT. See instructions on back of certificates.

Margaret Jenkins

D70713 HEALTH DEPARTMENT—CITY OF BALTIMORE D70713

CERTIFICATE OF DEATH. 74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2318 Boston St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Jenkins

(Residence in Baltimore: No. 2318 Boston St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH. Sept. (Month) 14 (Day) 1854 (Year)

7-AGE. 68 yrs. 3 mos. 19 ds. If LESS than 1 day, ..hrs. or ..min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). 037

9-BIRTHPLACE. (State or Country). Unknown

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER. (State or Country) unknown

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER. (State or Country) unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P. W. Johnson

(Address) 516 Eastern Ave

15- FILED JAN 3 - 1923 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan 1st (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..yrs. ..mos. ..ds.

(Signed) Thos. B. Norton M. D. (Coroner)

Jan 2nd 1923 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
N.W. Carmel Cem.	1/4 1923

20-UNDERTAKER. Geo. J. Ruth ADDRESS 1735 Hanford Ave

is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70714 D70714

CERTIFICATE OF DEATH.

31

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 N. Spring ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Williams Hericott

(Residence in Baltimore: No. 1816 N. Spring St.; 19 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	C	Married

6-DATE OF BIRTH, Oct (Month) 6 (Day), 1887. (Year)

7-AGE, 35 yrs. 2 mos. 25 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Cornelius Hericott

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER ~~Unknown~~ unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Jenkins wife

(Address) 1816 N. Spring St

15- FILED JAN 3 - 1923, 191... ROBERT R. KRAUTER, Registrar.
Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 31 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 19 22, to Dec 31 19 22, that I saw h[im] alive on Dec 30 19 22, and that death occurred, on the date stated above, at 2 [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculous Peritonitis and also [illegible] (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	Jan 3, 1923
20-UNDERTAKER	ADDRESS
Geo. J. Ruch	1735 Harford Ave.

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec. —6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70715

CERTIFICATE OF DEATH.

74-001 D70715

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 N. Rose ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice A. Bator

(a) RESIDENCE. No. 411 N. Rose ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph S. Bator

6 DATE OF BIRTH (month, day, and year) Aug. 17/1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Maryland

PARENTS

10 NAME OF FATHER Henry Funk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary A. Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County

11 Informant Howard C. Oliver (son)

(Address) 411 N. Rose St.

15 Filed JAN 3 - 1923 ROBERT R. KRAUTER, Registrar

Rachel Parrall Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1922, to Dec. 30, 1922, that I last saw her alive on Dec. 30, 1922, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) — yrs. — mos. 23 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock, M. D.

, 19 (Address) 15 W. St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	1/4/1923
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Hartford

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70716

CERTIFICATE OF DEATH.

99-002 D70716

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1213 Harlem Ave ST. 16 WARD)

2-FULL NAME John A. Dailey

(a) RESIDENCE. No. 1213 Harlem Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Virginia Dailey

6 DATE OF BIRTH (month, day, and year) March 18, 1859

7 AGE — Years: 63 — Months: 9 — Days: 15 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer): 59

(c) Name of employer

9 BIRTHPLACE (city or town) Frostburg (State or country) Md

PARENTS

10 NAME OF FATHER Cornelius Dailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Courtney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Frank J Dailey
(Address) 1213 Harlem Ave

15 FILED JAN 3 — 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1922, to Jan 2, 1923
that I last saw h[illegible] alive on Jan 2, 1923
and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) ... yrs. 4 mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J. Munroe, M. D.

1-2, 1923 Address) 516 N. Fremont ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ New Cathedral — DATE OF BURIAL JAN 4 1923

20 UNDERTAKER Geo W. Little — ADDRESS 2700 EDMONDSON AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70717 D70717

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3329 PAINE ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Miller

(a) RESIDENCE NO. 3329 PAINE ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) NOV. 21 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City Md

PARENTS

10 NAME OF FATHER: Stanley Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass

12 MAIDEN NAME OF MOTHER: Bertha Sherman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Bertha Miller

(Address) 3329 PAINE ST

15 Filed JAN 3 - 1923, 19... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 2 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922, to Dec. 2, 1923, that I last saw her alive on Dec 2, 1923, and that death occurred, on the date stated above, at 955 Pm.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) acute Rheumatism

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) C. J. Daner M. D.

1-8-, 1923 (Address) 806 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hampden

DATE OF BURIAL: 1/4 1923

20 UNDERTAKER: J. Walter Davis

ADDRESS: 3307 Paine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70718 D70718

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 Light St ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Ann Gunkel.

(a) RESIDENCE NO. 1701 Light St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Gunkel

6 DATE OF BIRTH (month, day, and year): May 15 1850

7 AGE: Years 72 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Conway

PARENTS

10 NAME OF FATHER: Jacob Gunkel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Conway

12 MAIDEN NAME OF MOTHER: Emma Hyneman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Emma Gunkel (Address): 1701 Light St

15 Filed JAN 3 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Jan 2, 1923

that I last saw h[illegible]alive on Jan 2, 1923,

and that death occurred, on the date stated above, at 1:15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

from History (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Markham, M. D.

Jan 2 1923 (Address) 3100 Kenfield Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount DATE OF BURIAL: Jan 1923

20 UNDERTAKER: H. Curtis Wood ADDRESS: Baltimore

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70719

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

159-002 D70719

Registered No. C.....

City of BALTIMORE: (No. 108 E. Montgomery St. St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Ivy B. Geoghegan Jr. ..... ----- 3 --- 14.

(Residence in Baltimore: No. 108 E. Montgomery St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. September 19, 1922.
(Month) (Day) (Year)

7-AGE. --- yrs. 3 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Ivy B. Geoghegan Sr.

11-BIRTHPLACE OF FATHER. (State or Country). Dorchester Co. Md.

12-MAIDEN NAME OF MOTHER. M. Madalene Mitchell.

13-BIRTHPLACE OF MOTHER. (State or Country). Berlin Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ivy B. Geoghegan. (father).

(Address) 108 E. Montgomery St.

15- Filed JAN 3 - 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 2nd, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Jan 3, 1923. (Address) 1017 E. Charles st.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Cross. A.A.Co. Md. DATE OF BURIAL, Jan 3 1923

20-UNDERTAKER, John F Penny ADDRESS 715 Light st

Spec.—1-10-21—M&T—1500 Bks.

D70720 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D70720

CERTIFICATE OF DEATH. 100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2136 N. Smallwood St., 9th 15 WARD)

2-FULL NAME Ada Exler

(a) RESIDENCE NO. 2136 N Smallwood St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? / yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Exler

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Shankerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Goldie Shankerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Balto St

15 FILED JAN 3 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1922, to Jan 3, 1923, that I last saw h[er] alive on Jan 2, 1923, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2136 N. Smallwood

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jack Lewis M. D.

1-3, 1922 (Address) 223 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehrem Rosedale — DATE OF BURIAL 1/3 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Wm W Robinson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70721

CERTIFICATE OF DEATH.

74-001

D70721

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3911 Roland Ave St.; 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. W. Robinson

(Residence in Baltimore: No. 3911 Roland Ave St.; yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 23 (Month) (Day), 1857 (Year)

7-AGE, 66 yrs. — mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Wm Robinson

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER R Edwards

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary S Robinson

(Address) 3911 Roland Ave

15-

Filed JAN 3 - 1923, 191

ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 2 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and viewed same; that I made inquiry thereon and from the evidence obtained by said Inquest, and from the records of Vital Statistics, and that said deceased came to ... death by the cause stated below, to wit: (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs.....mos.....ds.

(Signed) John Scrivener M. D.
(Coroner)

Jan 3, 1923 (Address) 302 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Bledsoe Va

DATE OF BURIAL, 1/3, 23

20-UNDERTAKER Geo J Smith

ADDRESS 1100 N Fayette

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D70722

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 N- Bond ST., 6 WARD)

2-FULL NAME John. Dean.

(a) RESIDENCE NO. 420 N- Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 6, '22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Walter Dean

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Ethel Keen

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Ethel Dean
(Address) 420 N. Bond St.

15 Filed JAN 3 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 2 - 1923

17 I HEREBY CERTIFY, That I attended deceased from 1 - 1 - 1923 to 1 - 2 - 1923, that I last saw him alive on 1 - 2 - 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

over

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Cargill, M. D.

1-2-1923 (Address) 611 - N - Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge, Md — DATE OF BURIAL Jan 3 1923

20 UNDERTAKER Mrs J. G. Locke — ADDRESS 1302 Jefferson St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary.

D70723 HEALTH DEPARTMENT—CITY OF BALTIMORE D70723

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hanover & Cromwell Sts. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August J. Raisler.

(Residence in Baltimore: No. 1424 Andre St. St.; 22 yrs. 6 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. June 27, 1900. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
22 yrs. 6 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Longshoreman.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Sylvester Raisler.

11-BIRTHPLACE OF FATHER, (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Augusta Kaminsky.

13-BIRTHPLACE OF MOTHER, (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Augusta Raisler. (mother).

(Address) 1424 Andre Street.

15- Filed JAN 3 - 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. December 31st, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull, laceration of brain
produced while riding in automobile
recklessly driven into telephone pole
Homicide. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) Chas. W. Reinhardt M. D.
(Coroner.)

Jan. 1, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Edgewood DATE OF BURIAL. 1/3 1923

20-UNDERTAKER. J. F. Talley & Sons ADDRESS 818 Fidelity St.

Spec.– 1-10-21– M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70724 90 D70724

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 517 W. Biddle St ST., 17 WARD)

2-FULL NAME Louisa Ann Hall

(a) RESIDENCE NO. Shelter for Colored People ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. + mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word)
F.	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) (?)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 90 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework - Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Nurse 070

(c) Name of employer Mrs. John D. Howard 157 W. Lanvale St

9 BIRTHPLACE (city or town) Montgomery Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Hall

11 BIRTHPLACE OF FATHER (city or town) – (Slave)
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Mrs. Catherine C. Dowling
(Address) 517 W. Biddle St - Baltimore, Md.

15 Filed JAN 3 – 1923, 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from July, 1922, to ~~Dec. 2~~ Jan. 2, 1923, that I last saw h[er] alive on Dec. 23, 1922, and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age
Arteriosclerosis
Myocardial insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Mary A. Hobbs, M. D.

, 19 (Address) 943 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel - Cem | DATE OF BURIAL Jan 5 1923

20 UNDERTAKER Chas. E. Barnett & Madison | ADDRESS

IMPORTANT. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D70725

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 129 D70725

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 N. Spring ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Bonsack

(Residence in Baltimore: No. 506 N. Spring St.; 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	C	Widowed

6-DATE OF BIRTH, ... (Month) ..... (Day) 1863 (Year)

7-AGE, 60 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): No

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Richard Robinson

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Cecelia Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Elizabeth Wise

(Address) 506 N. Spring

15- Filed JAN 3 - 1923 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, [redacted] (Month) Jan (Day) 1 (Year) 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 1922, to Jan 1 1923, that I saw her alive on Dec 31 1922, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) R. L. Hossang M. D.

1/3, 191.. (Address) 1119 E. Belvedere

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetary DATE OF BURIAL, Jan 4, 1923

20-UNDERTAKER Joseph T. H. Rochester ADDRESS 1413 E. Fayette St

Spec.—1-10-21—M&T—1500 Bks.

Hillcrest
108 - E. North =

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70726

CERTIFICATE OF DEATH.

74-001 D70726

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 410 E. North St. Hosp. WARD)

2-FULL NAME Catherine E. Rolker

(a) RESIDENCE NO. 410 E. North ST. Hos WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Rolker

6 DATE OF BIRTH (month, day, and year) March 27-1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

837

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Suethaus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gentown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John G. Rolker

(Address) 410 - E - North Ave

15 Filed JAN 3 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1922, to Jan 2 - , 1922, that I last saw h alive on Jan 2 - , 1922, and that death occurred, on the date stated above, at 945 P m.

The CAUSE OF DEATH* was as follows: Fatal heart bronchitis, Had a cerebral hemorrhage 2 yrs ago - recovered apparently completely -

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) Irving Hillcrest M. D.

, 19 (Address) 108 E. North Ave -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Baltimore Cemetery

DATE OF BURIAL 1/5 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E North.

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

D70727

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70727

CERTIFICATE OF DEATH.

REGISTERED NO. C 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3514 Fairview Ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H Burman

(Residence in Baltimore: No. 3514 Fairview Ave St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 21, 1882
(Month) (Day) (Year)

7-AGE, 40 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Real Estate
(b) General nature of Industry, business, or establishment in which employed (or employer): for self

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. John H. Burman

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Louisa Petrate

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Augusta L. Burman.

(Address) 3514 Fairview Ave

15-

Filed JAN 3-1923 191.... ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 2, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 15 1916, to Jan 2 1923, that I saw h[illegible] alive on Jan 1 1923, and that death occurred, on the date stated above, at 7:55 a.m.

The CAUSE OF DEATH* was as follows:

1 Tuberculosis

(Duration) 5 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Anemia - Endocarditis

(Duration) ....yrs. ....mos. ....ds.

(Signed) Walter L. Kenny M. D.

Jan 2, 1923 (Address) 3517 Fairview Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Rosmont

DATE OF BURIAL, 1-5, 1923

20-UNDERTAKER Mrs Chas A Rohde

ADDRESS Arlington

If OCCUPATION is very ... on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70728

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D70728

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 E West ST. 23 WARD)

2-FULL NAME Annie R. Smith.

(a) RESIDENCE NO. 205 E West ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert L. Smith.

6 DATE OF BIRTH (month, day, and year): Nov 25-1890

7 AGE: 32 Years | Months | Days | If LESS than 1 day, hrs. or min.
32.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Harry. Mc Mahan.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Boston. Mass

12 MAIDEN NAME OF MOTHER: Ella. Garland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Robt. L. Smith 205 E West St

15 Filed JAN 3-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10/22, 19 ..., to Jan 1/23, 19 ..., that I last saw h alive on Dec 31/22, 19 ..., and that death occurred, on the date stated above, at 9 45 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ..... yrs. 3 mos 20 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ..... yes .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Autopsy

(Signed) Henry B Kolb, M. D.
Jan 1/23 (Address) 1103 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters — DATE OF BURIAL 1-4 1923

20 UNDERTAKER: E & B Hahn 116 — ADDRESS E West 88

CAUSE OF DEATH must be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Nephritis

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70729

CERTIFICATE OF DEATH.

93

D70729

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) St. Joseph's Hospital (ST.) 9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sr. M. Cordula Berard

(a) RESIDENCE NO. St Joseph's Hospital (ST.) (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 6 1854

7 AGE: Years 68. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

165

9 BIRTHPLACE (city or town) (State or country) Rochester N.Y.

PARENTS

10 NAME OF FATHER John F. Berard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) Records of St Josephs Hospital Caroline & Hoffman Sts

15 Filed JAN 3 — 1923 ROBERT R. KRAUTER, Registrar

Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 28 1922 to Jan. 2 1923

that I last saw her alive on Jan 2 1923

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Phlebitis (thigh)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Schumacher, M. D.

19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Jan. 4 1923

20 UNDERTAKER: Henry Stock & Son — ADDRESS: 120 E Eager St

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70730

CERTIFICATE OF DEATH.

44 D70730

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1809 N. Regester ST., 8 WARD)

2-FULL NAME Emma C. Crosby.

(a) RESIDENCE NO. 1809 N. Regester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Harry Crosby

6 DATE OF BIRTH (month, day, and year) June 29 1869

7 AGE: Years 53 Months 11 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John J. Schauermann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Scholl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. L. Schauer (Address) 1809 N. Regester st

15 Filed ..... 19 ..... Registrar ROBERT H. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2nd 1923

17 I HEREBY CERTIFY, that I attended deceased from Feb. 1, 1922 to Jan. 2, 1923

that I last saw h alive on 19;

and that death occurred, on the date stated above, at 12 30 p m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver (Carcinoma)

(duration) yrs 11 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 1922

Was there an autopsy? No

What tests confirmed diagnosis? Typical

(Signed) J. Rivinbach M. D.

(Address) 1512 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Jan 5 1923

20 UNDERTAKER: Henry Horch Sons — ADDRESS: 130 E Eager st

TION is very important. See instructions on back of certificates. ...ng as property. Classified. EXACT statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70731

CERTIFICATE OF DEATH.

90 D70731

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1730 Bolton. ST., 14 WARD)

2-FULL NAME Mary L. Fitzgerald

(a) RESIDENCE No. 1730 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Fitzgerald

6 DATE OF BIRTH (month, day, and year): Jan 11 1838

7 AGE — Years: 84 Months: 11 Days: 21 If LESS than 1 day.....hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Cumberland Md.

PARENTS

10 NAME OF FATHER: Philip D. Lipscomb

11 BIRTHPLACE OF FATHER (city or town) (State or country): U. S.

12 MAIDEN NAME OF MOTHER: Maria Goth.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Miss Mamie Lipscomb 1730 Bolton St

15 Filed Jan 3 1923, 19 ROBERT R. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 19, 19 22, to Jan 2, 1923,

that I last saw her alive on Jan 1, 1923,

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary): Mitral Regurgitation

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) A. R. Duvall, M. D.

Jan 7 19 23 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Jan 5 1923

20 UNDERTAKER: Latham & Gore

ADDRESS: 1723 N Longwood

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70732

CERTIFICATE OF DEATH.

101-001

D70732

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 Cherry Ave (Rasreburg) ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Anna Stachnick

(a) RESIDENCE No. 29 Cherry Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed,~~ ~~or Divorced,~~ (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Stachnick

6 DATE OF BIRTH (month, day, and year) April 26th, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co. (State or country) Md.

PARENTS

10 NAME OF FATHER William Seitz

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Barbara Knauer

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant John Stachnick

(Address) 29 Cherry Ave

15 Filed JAN 3 - 1923 19 ROBERT R. KNABLE Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1st, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1922, to Jan 1, 1923, that I last saw her alive on Jan 1, 1923 and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Thomas, M. D.

Jan 2 1923 (Address) 3100 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Jan 4th, 19 23

20 UNDERTAKER Bertram W. Fork

ADDRESS 1733 W. Lafayette Ave

FORM is very important. See instructions on back of certificates. Exact statement of OCCUPA-

(Burns)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70733
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 D70733
Registered No. C.....

City of BALTIMORE: (No. 511 Stricker St at Camden Nelson 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Burns

(Residence in Baltimore: No. 522 N Stricker St St.; yrs....., mos....., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Don't Know

6-DATE OF BIRTH: Don't Know (Month) (Day) 1..... (Year)

7-AGE: about 70 yrs ..... mos. ..... ds.
If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Don't Know
(b) General nature of industry, business, or establishment in which employed (or employer): 081

9-BIRTHPLACE, (State or Country): Don't Know

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER, (State or Country), [illegible]

12-MAIDEN NAME OF MOTHER, [illegible]

13-BIRTHPLACE OF MOTHER, (State or Country), [illegible]

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Department

(Address) Western

15-

Filed JAN 3 - 1923 By ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec (Month) 26 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(Duration) ..... yrs. Don't Know mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. K. Gormley M. D. (Coroner.)

1-3 1923 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. ~~Mt Olivet Cemetery~~ Dr. Peters — DATE OF BURIAL, Jan 4 1923

20-UNDERTAKER. W. M. Routson — ADDRESS 230 N Greene

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70734 CERTIFICATE OF DEATH. X 10 D70734

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (ST.) (WARD)

2-FULL NAME Dorothy Lewis

(a) RESIDENCE. NO. 2529 Emerson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) oct 18-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md

PARENTS

10 NAME OF FATHER Wm. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Rose Woodland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Md

14 Informant Wm. H. Lewis
(Address) 2529 Emerson St

15 Filed JAN 3 - 1923, 19 ROBERT R. KRAUTER Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/2/23

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1922, to Jan 2, 1923, that I last saw her alive on Jan 2, 1923, and that death occurred, on the date stated above, at 12:10 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, tonsillar + pharyngeal

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. — mos. 9 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) Ella Lazarus M. D.

, 19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: Jan 3 1923

20 UNDERTAKER: George L. Schwartz

ADDRESS: 901 Eutaw Ave.

FOR IS very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70735

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70735

CERTIFICATE OF DEATH.

38

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 511 S. Chester ST., 1 WARD)

2-FULL NAME Herman Willheim

(a) RESIDENCE NO. 511 S. Chester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Willheim

6 DATE OF BIRTH (month, day, and year) Oct 7, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant (Address) Lena Willheim 511 S. Chester St

15 JAN 3-1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1922, to Jan 1, 1923,

that I last saw h/s alive on Jan 1, 1922,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

Cardiac Insufficiency

(duration) ... yrs. 4 mos 9 ds.

CONTRIBUTORY (Secondary) Senile

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Herman L Deuber, M. D.

, 19 (Address) 332 S Paul Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st Evangelical Cemetery	Jan 4 1923
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70736 D70736

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 Mt. Royal Avenue ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Breedlove

(a) RESIDENCE NO. 1422 Mt. Royal Avenue ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 8 mos. 10 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Breedlove

6 DATE OF BIRTH (month, day, and year) April 22, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Valentine Dieter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Dielman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Clarence M. Griffin
(Address) 1422 Mt. Royal Avenue

15 Filed 1923 by Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 28, 1920 to Jan 1, 1923.

that I last saw her alive on Jan 4, 1923

and that death occurred, on the date stated above, at 6p m.

The CAUSE OF DEATH* was as follows:

Myocardial, insufficiency

Do not know duration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

Do not know (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Howard Streett, M. D.

(Address) 712 Park ave Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 1/4 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70737 HEALTH DEPARTMENT—CITY OF BALTIMORE D70737

CERTIFICATE OF DEATH. 162

1-PLACE OF DEATH Johns Hopkins Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 3 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Simber sdt S. Bond sp

(a) RESIDENCE NO. John Hopkins Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 hrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec - 31 - 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, 9 hrs. or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Berlin Mass
(State or country)

PARENTS

10 NAME OF FATHER Albert Simber

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Alexandria Dalkowski

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant W.W. Gray
(Address) Johns Hopkins Hospital.

15 Robert F. Harrison, M.D.
Registrar

3 - 1923

District Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec - 31 1922.

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1922, to Dec 31, 1922,

that I last saw her alive on Dec 31, 1922,

and that death occurred, on the date stated above, at 3.06 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? yes

What test confirmed diagnosis? —

(Signed) W.W. Gray, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19 3

20 UNDERTAKER

ADDRESS

Commissioner Health.

JAN 3 - 1923

Now is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D70738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-003 D70738

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Spotsey

(a) RESIDENCE NO. 710 Mosher ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 13 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec - 13 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	0	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Weeks

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Ollie Spotsey

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant W.W. Gray (Address) Johns Hopkins Hospital.

15 Filed ..... , 19 ..... Robert F. Garrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec - 27 1922.

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1922, to Dec 27, 1922, that I last saw h[illegible] alive on Dec 27, 1922, and that death occurred, on the date stated above, at 10 15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? yes.

What test confirmed diagnosis? .....

(Signed) W.W. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL JAN 3 - 1923

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner of Health.

Form is very important. See instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital Malformation of Brain.

D70739 HEALTH DEPARTMENT—CITY OF BALTIMORE D70739

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. 6 Cookie Ct St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Burrell

(Residence in Baltimore: No. 6 Cookie Ct St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.): Unknown

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: about 35 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept.

(Address) Eastern Dist

15-

Filed ..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, Dec. 24 (Month) (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Lungs

(Duration) unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)

Jan 2nd 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Accidental

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, JAN 3 - 1923

20-UNDERTAKER, ADDRESS

Robert F. Harrison, Commissioner Health.

Permit Clerk.

JOHNS HOPKINS HOSPITAL

THE MORGUE

Rec. W. E. WOODALL

D70740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70740

CERTIFICATE OF DEATH.

6 197

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hosp. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Mrs Harris (Unknown as .....

(Residence in Baltimore: No. 232 N. Bond ..... St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. unknown ..... 1.....
(Month) (Day) (Year)

7-AGE. unknown about 25 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. 3 ft gun Tail
(b) General nature of industry, business, or establishment in which employed (or employer). Weight 150 lb

9-BIRTHPLACE, (State or Country). unknown

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country). unknown

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Franklin Parker

(Address) Stables

15 Filed ..... 192 ..... Registrar.

Robert F. Parrison,
Burial Permit Clerk

-1923

(011 THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 21 192.2
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide bullet wound left side in pons & upper cervical Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

12-27 ..... 192.2 (Address) ..... E. Monument

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL, ... 192 .....

20-UNDERTAKER. ADDRESS

JOHNS HOPKINS HOSPITAL
(SUPERINTENDENT'S STATION)
Per Wm. F. WORRALL

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70741 D70741

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 S. Register ST.: W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hoornlein

(a) RESIDENCE. No. 9 S. Register ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or Divorced (write the word): widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of ~~(or WIFE of)~~ Temperance Hoornlein.

6 DATE OF BIRTH (month, day, and year) Apl-19-1863

7 AGE: Years 59 | Months 8 | Days 14 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bernard Hoornlein

(Address) 9 S. Register St.

15 Filed 19 Robert F. Carrison, Registrar

1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1923

17 I HEREBY CERTIFY, That I attended ~~deceased~~ from ~~Jan~~ Dec 31, 1922, to Jan 1st, 1923, that I last saw ~~him~~ alive on Jan 1st 1923, and that death occurred, on the date stated above, at 12:45 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J. W. Wade, M. D.

, 19 (Address) 118 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: 1/5/23 19

20 UNDERTAKER: Milton W Jones — ADDRESS: 418 S Broadway

Spec. instructions on back of certificates. Cause of death, Duration of illness, Statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70742

CERTIFICATE OF DEATH.

164 D70742

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: NO. 1713 Mosher ST. 16 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel Shaw

(a) RESIDENCE. NO. 1713 Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (~~or WIFE of~~) Sarah Jane Shaw

6 DATE OF BIRTH (month, day, and year) Feb. 14. 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. Railway Balto. Co

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Jacob Shaw

11 BIRTHPLACE OF FATHER (city or town) Washington Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susana Myers

13 BIRTHPLACE OF MOTHER (city or town) Washington Co. (State or country) Maryland.

14 Informant Carrie B. Peace (Address) 1713 Mosher St.

15 Filed Jan 5, 1923 ROBERT P. GARRISON, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 24th, 1922, to Jan. 2nd, 1923, that I last saw h~~im~~ alive on Jan 2nd, 1923, and that death occurred, on the date stated above, at 9 10 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia with Coronary Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clement Evans, M. D.

Jan 5 1923 (Address) 833 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	1/5/23 19

20 UNDERTAKER H. E. Hughes ADDRESS 434 N. Broadway

Any information desired will be furnished by the Registrar. See instructions on back of certificates.

D70743

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80 D70743

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 815 Warner Street St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred V. Young. (C).

(Residence in Baltimore: No. 815 Warner Street. St.; 1 yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	Colored.	Single.

6-DATE OF BIRTH. December 2, 1921.
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
1 yrs. 1 mos. --- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Norman Jackson. (C).

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Blanche Young. (C).

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Young. (C) (mother).

(Address) 815 Warner Street.

15- Filed JAN 4 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 2nd, 1923.
(Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dentition.

Eclambsia.

(Duration) ....yrs. ....mos. ....ds

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

Jan 3, 1923. (Address) 1017 E. Charles st.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, Jan 4 1923

20-UNDERTAKER, Jno. H. Toadvine & Sons ADDRESS 142 Eutaw St

Very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70744

CERTIFICATE OF DEATH.

31

D70744

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Chester

(a) RESIDENCE NO. 548 Orchard st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Unknown~~ Life. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not stated

6 DATE OF BIRTH (month, day, and year) 1900 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Briscoe Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Julia Messick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records

(Address) [illegible] M.T.H.

15 Filed JAN 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1, 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1922, to Jan. 1, 1923,

that I last saw her alive on Jan. 1, 1923,

and that death occurred, on the date stated above, at 4.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) A. A. Lucke, M. D.

1-2-23, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL: Tuberculosis

DATE OF BURIAL 1/4/23

16 UNDERTAKER: Edward J. Kennedy

ADDRESS 1 Biddle

Sex.—Important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

D70745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X129 D70745

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 25 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Cunningham

(a) RESIDENCE NO. Annapolis Junction (St.) Howard Co. (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 30 mos. 5 ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): M

5a If married, widowed or divorced (HUSBAND) of (or) WIFE of: J. Cunningham

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know

14 Informant: J. Cunningham (Address) 121 W. Charles St

15 Filed JAN 4 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 3, 1923, that I last saw h[er] alive on Jan 3, 1923, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis - Chr. Uremia

Cardiac Insufficiency

Not Known (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

Pulmonary Edema (duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Caldwell, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Jan 6th 1923

20 UNDERTAKER: Geo J. Rust ADDRESS: 1735 Hartford ave.

(Supplementary Items: See instructions on back of certificates.)

Spec. 1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70746

CERTIFICATE OF DEATH.

D70746

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital St. 76 WARD)

2-FULL NAME Noah Hallinshead alias Frank Hallis

(a) RESIDENCE NO. ? ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
Unknown About 35				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer) ? 87

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Hosp. Records
(Address)

15 Filed JAN 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 1 - 1923

17 I HEREBY CERTIFY, That I attended deceased from 12-31-, 1922 to 1-1-, 1923.

that I last saw h~~im~~ alive on 12-31-1922.

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(duration) yrs. 2 mos. 1? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Clyde McReid, M. D.

1/2, 1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Jan 4th 1923

20 UNDERTAKER George J. Ruth

ADDRESS 1435 Harford Ave

IMPORTANT—Answer every question. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70747 11-001 D70747

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1352 Fremont Ave ST. 15 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dorsey

(a) RESIDENCE No. 1352 Fremont Ave, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced — ~~HUSBAND~~ of (or) WIFE of Moses Dorsey

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co (State or country) Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Raymond Dorsey

(Address) 352 Fremont Ave

15 Filed JAN 4 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1922, to Jan 1, 1923, that I last saw her alive on Jan 1, 1923 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

1a La Grippe

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Frey, M. D.

1/2, 1923 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 5 1923
20 UNDERTAKER	ADDRESS
Edward Pingfold	1103 Carey St

THIS IS VERY IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D70748

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70748

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1716 Brunt ST. 14 WARD)

2-FULL NAME Lina White

(a) RESIDENCE NO. 1716 Brunt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): Jan 14. 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bundle Wrapper

(b) General nature of industry, business, or establishment in which employed (or employer): Laundry

(c) Name of employer: Elite Laundry

9 BIRTHPLACE (city or town) St. Mary Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER: Frank White

11 BIRTHPLACE OF FATHER (city or town) St Mary Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER: Lizzie Burns

13 BIRTHPLACE OF MOTHER (city or town) St Mary Co.
(State or country) Md

14 Informant: Frank White
(Address) 1716 Brunt St

15 Filed JAN 4 - 1923, 19 .....

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 31 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1922 to Dec 31, 1922,

that I last saw her alive on Dec 31, 1922,

and that death occurred, on the date stated above, at 7-30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) ..... yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clin. Findings

(Signed) Paul Brown, M. D.

1/1, 1923 (Address) 1837 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Jan 4 1923

20 UNDERTAKER: Edward Ruppert — ADDRESS: 1463 D. Ave

Long imperial. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Jesclunas

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70749 D70749

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (St.:) 4 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Jesclunas

(a) RESIDENCE. No. 641 W. Lombard St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosona Anna

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Michael Jesclunas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Mary Kelleecree

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant P. Belis

(Address) 830 Hollens Street

15 Filed JAN 4 1923 ROBERT R. KRAETZER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922, to January 2, 1923, that I last saw him alive on January 2, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cachexia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. J. Fulton, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan. 4. 1923

20 UNDERTAKER	ADDRESS
John Grebliauckas J. G.	425 S Paca St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

J Shwab

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70750 CERTIFICATE OF DEATH. 71-02 D70750

1-PLACE OF DEATH St. Joseph's Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kolpek

(a) RESIDENCE NO. 1509 Pennington Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labar

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer — — —

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Feleks Koepek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Anne Tirwilute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Joseph Bayoras

(Address) 1503 Pennington Ave

15 JAN 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2, 19 23

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 19 22 to Jan. 2, 19 23

that I last saw him alive on Jan. 2, 19 23

and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebro-Spinal Meningitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Custer Boy

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) J. J. Kraye, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Janv. 4. 1923
20 UNDERTAKER	ADDRESS
John Grebliauckas J.G.	425 S. Paca St

Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70751

CERTIFICATE OF DEATH.

100-001

D70751

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Thomas

(a) RESIDENCE NO. 1220 S. Clinton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	58	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Weigher

(b) General nature of Industry, business, or establishment in which employed (or employer) D86

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed JAN 4 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1 19 23

17

I HEREBY CERTIFY, That I attended deceased from December 29, 19 22, to January 1, 19 23, that I last saw him alive on December 31, 19 22, and that death occurred, on the date stated above, at 1:45 A. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Clyde M. Neal, M. D.

1/2, 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lindy Cem DATE OF BURIAL Jan 4 19 23

20 UNDERTAKER Robt S. Little ADDRESS 570 Edmondson Av

Instructions: See instructions on back of certificates. Statement of OCCUPA-

D70752

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70752

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hotel near Park Ave 14 Registered No. C.....

City of BALTIMORE: (No. (Forbes) Mc Mechen St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Jefferson Talbott, M.D.

(Residence in Baltimore: No. The Marlborough Apts. St.; yrs. 47 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. February 17th 1875
(Month) (Day) (Year)

7-AGE. 50 yrs. 10 mos. 15 ds. If LESS than 1 day, ...hrs. or....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Laurel, Md.

PARENTS.

10-NAME OF FATHER. Thomas J. Talbott

11-BIRTHPLACE OF FATHER, (State or Country). Laurel, Md.

12-MAIDEN NAME OF MOTHER. Martha R. Waters

13-BIRTHPLACE OF MOTHER, (State or Country). Carroll Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary J. Talbott

(Address) The Marlborough Apts.

15- FILED JAN 4 - 1923. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. January 1st 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

angina pectoris

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) uro histrogen

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jno. T. Hennessy, M. D. (Coroner.)

Jan. 2 1923 (Address) 4306 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Druid Ridge Cem. DATE OF BURIAL. Jan 4" 1923

20-UNDERTAKER. Jacob B. Cook ADDRESS 1003 N. Gilmor St.

Spec.—1-10-21—M&T—1500 Blks.

D70753

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D70753

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3014 Roseland Pl ST., 20 WARD)

2-FULL NAME Katherine Dempsey

(a) RESIDENCE NO. 1954 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs mos. ds. How long in U. S., if of foreign birth? [redacted] mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Dempsey

6 DATE OF BIRTH (month, day, and year) July 7, 1847

7 AGE: Years 75 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER Thos Cummins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Mary Cummings

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs Mary A Webb 1954 W Fayette St

15 JAN 4 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1923

17 I HEREBY CERTIFY, That I attended deceased from November 1922 to now Jan 2nd 1923. 1 visit

that I last saw her alive on Jan 2nd 1923

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema perhaps since Nov 22 when similar yielded to treatment (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Dilated Heart ? Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Chas S Parker M. D.

, 19 (Address) 3106 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Jan 5 1923

20 UNDERTAKER: John J Toale — ADDRESS: 1201 N Lombard

See instructions on back of certificates. Space for Statement of OCCUPA-

Spec. 6-9-19—H. P. Co.—1000 Bks.

D70754

HEALTH DEPARTMENT—CITY OF BALTIMORE

74001 D70754

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2424 E. Fall (St.) 26 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Knorr

(a) RESIDENCE. No. 2424 E Fall St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Henry Knorr.

6 DATE OF BIRTH (month, day, and year) Aug 15 1838

7 AGE: Years 84 Months 4 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Wm. Leach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER Elizabeth Jefferson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant Emma B. Knorr Heinz

(Address) 2424 E Fall.

15 Filed JAN 4 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from July, 1922, to Jan, 1923, that I last saw h[illegible] alive on Jan. Dec 30, 1922, and that death occurred, on the date stated above, at 12 45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo S Bunnett, M. D.

, 19 (Address) 218 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland

DATE OF BURIAL: Jan 6 1923

20 UNDERTAKER: Perkins & Perkins

ADDRESS 1734 Eager

Fill in all items. See instructions on back of certificates. OCCUPA-

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70755

CERTIFICATE OF DEATH.

187-007

D70755

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Md. Gen. Hospital St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Frank J. Shimek

(Residence in Baltimore: No. 352 E. Fairmount Av St.; 42 yrs., 7 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	Married

6-DATE OF BIRTH. May 23, 1880
(Month) (Day) (Year)

7-AGE. 42 yrs. 7 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer): Bethlehem Steel Co.

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Frank Shimek

11-BIRTHPLACE OF FATHER, (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER. Dorit Kusy

13-BIRTHPLACE OF MOTHER, (State or Country). Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. Shimek

(Address) 352 E. Fairmount Av.

15- JAN 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan. 2, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractures of both arms & r. leg.
(accidental) (Accident at Bethlehem Steel Co.)
(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia
(Duration) ....yrs. ....mos. 1 ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Jan. 3, 1923 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oaklawn	Jan 5 1923

20-UNDERTAKER.	ADDRESS
Zickler & Zickler	1739 Eager st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70756

101-001 D70756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Royal Court apts ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Rosenfeld

(a) RESIDENCE NO. Lake Louise + Callow Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Rosenfeld

6 DATE OF BIRTH (month, day, and year) Feb 8 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Moses Rosenfeed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Newfeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jack Levy

(Address) 1439 E Baltimore St

15 FILED JAN 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 25, 1922, to Jan 2nd, 1923,

that I last saw him alive on Jan 1st, 1923,

and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar - right)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Michael J. Brand, M. D.

, 19 (Address) 1800 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bara Hebrew Cem

DATE OF BURIAL Jan 4 1923

20 UNDERTAKER Levy Bros

ADDRESS Fort Lewis, 1439 E. Balto

Sec. 3 Act of June 3, 1921. See instructions on back of certificates.

Important statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D70757

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-00 D70757

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ORLANDO AVE. NEAR HARFORD ROAD PARKVILLE. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME EDWARD JOSEPH SCHISLER

(a) RESIDENCE NO. ORLANDO AVE. NEAR HARFORD ROAD. PARKVILLE. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	INFANT

5a If married, widowed, or divorced ---------- HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) SEPT. 10 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	----------	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work INFANT

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) BALTO. (State or country) MARYLAND

PARENTS

10 NAME OF FATHER JOHN J. SCHISLER

11 BIRTHPLACE OF FATHER (city or town) BALTO. (State or country) MARYLAND

12 MAIDEN NAME OF MOTHER SARAH MAUL

13 BIRTHPLACE OF MOTHER (city or town) BALTO. CO. (State or country) MARYLAND

14 Informant JOHN J. SCHISLER (Address) PARKVILLE MD.

15 Filed JAN 4 - 1923 ROBERT R. KRAUTER, Register

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN. 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 31, 1922, to Jan 2, 1923, that I last saw h alive on Jan 2, 1923 and that death occurred, on the date stated above, at 7.30. A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of ---

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Henry Lantz, M. D.

Jan 3 1923 (Address) 27 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOLY REDEEMER CEMETERY — DATE OF BURIAL: JAN. 4 1923

20 UNDERTAKER: Fred'k Lassahn Sons — ADDRESS: FULLERTON. MD.

Sec. 2. For instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70758

CERTIFICATE OF DEATH.

1/24 D70758

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklyn Square Hospital ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Emma Fossett

(a) RESIDENCE. NO. 620 Crawford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 29th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER John Fossett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Rachel Lindeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Henry F Schroeder
(Address) 625 E 36th st

15 JAN 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 2 1923

17 I HEREBY CERTIFY, That I attended deceased from July 15 1921 to Jany 2 1923 that I last saw h alive on Jany 2 1923, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Aplastic Selerosis -
Chronic Nephritis
Acute Cyst A

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Adema Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of Dec 27/922

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physical

(Signed) J. W. Thomas, M. D.

Jany 2 1923 (Address) 1228 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jan 5th 1923
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70759 129 D70759

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2309 Greenmount St., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Callahan

(a) RESIDENCE NO. 2309 Greenmount ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ (or) WIFE of Thomas E Callahan

6 DATE OF BIRTH (month, day, and year) December 23rd 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) D37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James A Colbert

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary J Bidout

13 BIRTHPLACE OF MOTHER (city or town) Hampton (State or country) Va

14 Informant Thomas E Callahan
(Address) 2309 Greenmount ave

15 Filed JAN 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 19 23

17 I HEREBY CERTIFY, That I attended deceased from Dec 4 19 22, to Jan 2 19 23,

that I last saw h alive on Jan 2 19 23

and that death occurred, on the date stated above, at 11.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
High Blood Pressure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas B. Reese, M. D.

Jan 4 19 23 (Address) 830 Hollins st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Jan 5th 1923

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument st

FAILURE to fill out correctly and completely all items on this certificate is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70760

D70760

CERTIFICATE OF DEATH.

111-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Retreat St. ST. 13 WARD)

2-FULL NAME Harry Frederick Velker

(a) RESIDENCE NO. 1611 Retreat St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 11 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 20 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Piano Tuner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Fredk J. Velker

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Dennie Christ

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Edw. Velker
(Address) Catonsville Md

15 JAN 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1923

17 I HEREBY CERTIFY, That I attended deceased from October, 1922, to January 2, 1923, that I last saw h[illegible] alive on January 2, 1923, and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer over
Internal Hemorrhage

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cerebral Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) A. Ha. A. Mayer M. D.

1-2, 1923 (Address) 2438 Garland Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL Jan 5 1923

20 UNDERTAKER Wm Pickues Sons ADDRESS North Ave

Spec.—1-10-21—M&T—1500 Bks. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Perforating duodenal ulcers, due to gall Bladder trouble Pneu

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70761 D70761

CERTIFICATE OF DEATH.

101-002

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 132 Calvin ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Burk (or Bronnion or Braddi

(Residence in Baltimore: No. 132 Calvin St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Wid

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Lab
(b) General nature of industry, business, or establishment in which employed (or employer)..... do

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Henry Bronnicke

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Bronnicke

(Address) 132 Calvin St

15-

Filed JAN 4 1923, 191.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 2, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Jan 4, 1923 (Address) 1602 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL, Jan 7, 1923

20-UNDERTAKER John W Henderson & Monument

ADDRESS 1502

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70762

100-601

CERTIFICATE OF DEATH.

D70762

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1033 S Charles ST.: 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Selway, Jr

(a) RESIDENCE. No. 1033 S. Charles ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Selway

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary McNeir

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Wm Selway
(Address) 1033 S. Charles St

15 JAN 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 2 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/20/22 19 . to 1 - 2 - 23 19 .
that I last saw him alive on 1 - 2 - 23 .
and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) James Brown, M. D.

, 19 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	1/4/23 19
20 UNDERTAKER	ADDRESS
Jno J Doheny & Sons	1318 Light

Read carefully. Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D70763

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4709 York Road ST., 27 WARD)

2-FULL NAME John Jennott

(a) RESIDENCE NO. 4709 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mame Jennott

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE: Years 65; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Pat Jennott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. M. Jennott

(Address): 4709 York Road

15 Filed JAN 4 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 2 19 23

17 I HEREBY CERTIFY That I attended deceased from about 5-6 Dec 5 19 to Jan 2 19 23

that I last saw h alive on Jan 2 19 23

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) - Diabetes, Arterio Sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Urine - None

(Signed) Thos F Cowdy, M. D.

19 (Address) Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Garrison — DATE OF BURIAL: 1/5/23 19

20 UNDERTAKER: J. J. Tobey & Sons — ADDRESS: 131 S Eutaw

ATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Sidney V. Lewis ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70764

CERTIFICATE OF DEATH.

90 D70764

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2117 Lyndhurst ST. 15 WARD)

2-FULL NAME Mrs. Sidney Verdeen Lewis

(a) RESIDENCE NO. 2117 Lyndhurst ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE): Stephen Lewis

6 DATE OF BIRTH (month, day, and year): Nov 25-1854

7 AGE: Years 69 | Months 1 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ——— 87

(b) General nature of industry, business, or establishment in which employed (or employer): ———

(c) Name of employer: ———

9 BIRTHPLACE (City or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thos Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary J. Slocomb

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Baltimore Md

14 Informant (Address): Mrs. S. Lewis 2117 Lyndhurst

15 Filed JAN 4-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 3- 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov- 20, 1922 to Jan 3, 1923,

that I last saw her alive on Jan 3, 1923,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis with de-
compensation. (Senile)

(duration) ... yrs. 8 mos — ds.

CONTRIBUTORY (Secondary): Acute Dilatation

(duration) ... yrs. ... mos. 1 ... ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of ———

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) J. Wesley Cole, M. D.

1923 (Address) 220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Jan 6 23 19

20 UNDERTAKER: F. S. Shepherd

ADDRESS: 220 Fulton Ave

FROM A very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70765

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D70765

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 Wheeler Ave ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E Trenkle

(a) RESIDENCE NO. 16 Wheeler Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina E Trenkle

6 DATE OF BIRTH (month, day, and year) Mar 7 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Wm E Trenkle & Bro

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Trenkle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Hauck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Wm E Trenkle 16 Wheeler Ave

15 Filed JAN 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1922, to January 2, 1923, that I last saw him alive on Jan 2nd, 1923, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C E Benton, M. D.

1/2, 1923. (Address) 202 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Garden	Jan 5th 1923
20 UNDERTAKER	ADDRESS
J. D. Pippert	2256 Eutaw

FROM is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70766

CERTIFICATE OF DEATH.

16 161-001

D70766

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3504 Mt Pleasant St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Fittinger

(Residence in Baltimore: No. 3504 Mt Pleasant St.; 1/6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Jan 4, 1923 (Month) (Day) (Year)

7-AGE, ...yrs.....mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, George Fittinger

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Emma Zeusler

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Krauter

(Address) 3504 Mt Pleasant Ave

JAN 4 - 1923

ROBERT R. KRAUTER,

Filed....., 191.....

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 4, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1922 to Jan 4 1923, that I saw h[illegible] alive on Jan 4 1923, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) yrs. mos. 5 ds.

CONTRIBUTORY..... (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Maxwell L Mayer M. D.

Jan 4 1923 (Address) 3115 E Balt St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cemetery

DATE OF BURIAL, Jan 5th, 1923

20-UNDERTAKER Chas C Miller

ADDRESS 2334 Jefferson St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

73 D70767

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1106 S. Bouldin ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Kennedy

(a) RESIDENCE. No. 1106 S. Bouldin ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine (Kelly) Kennedy

6 DATE OF BIRTH (month, day, and year): 7/15/54

7 AGE — Years: 68 — Months: 5 — Days: 18 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED: Skilled Laborer

(a) Trade, profession or particular kind of work: watchman (pressure man) retired 2 years

(b) General nature of Industry, business, or establishment in which employed (or employer): Shipyard (Fairfield)

(c) Name of employer: Consolidated Gas Co.

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thomas Michael Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): John J. Kennedy (Son) 1106 S. Bouldin St.

15 Filed JAN 4 - 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 2 1923

17

I HEREBY CERTIFY, That I attended deceased from March, 1922, to Jan 2, 1923, that I last saw h.m alive on Dec 31, 1923, and that death occurred, on the date stated above, at 10¼ A. m.

The CAUSE OF DEATH* was as follows:

Progressive (Primary) Paralysis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility (Starvation)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. F. Wright, M. D.

1/3, 1923 (Address) 1145 S. Elwood Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL: Jan 5 1923

20 UNDERTAKER: Lilly & Zeile ADDRESS: 403 S. Broadway

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70768 ✓ 31 D70768

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 408 E. Lanvale St

REGISTERED NO.

CITY OF BALTIMORE: (No. 408 E Lanvale ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Kate Yeagy

(a) RESIDENCE. No. 408 E. Lanvale ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George C Yeagy

6 DATE OF BIRTH (month, day, and year) May 15 - 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Hanover Pa

PARENTS

10 NAME OF FATHER John G. Baschore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover Pa

12 MAIDEN NAME OF MOTHER Anna Schwarthange

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover Pa

14 Informant George E. Yeagy
(Address) 408 E. Lanvale St

15 Filed JAN 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from August 1922 to January 2nd 1923.

that I last saw her alive on January 2nd 1923.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum Examination

(Signed) Chas. D. Hogan, M. D.

19 (Address) 7 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park	Jan. 6 1923

20 UNDERTAKER	ADDRESS
Josiah Syfer	1600 N. North Ave

THIS IS VERY IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70769 HEALTH DEPARTMENT—CITY OF BALTIMORE D70769

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST., 17 WARD)

2-FULL NAME Henry H. Owens

(a) RESIDENCE NO. 25 Cold Spring ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Owens

6 DATE OF BIRTH (month, day, and year) June 14 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance agent

(b) General nature of industry, business, or establishment in which employed (or employer) Home Friendly Ins. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Marcellus Owens

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Venable

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Frances Owens

(Address) 25 Cold Spring ave

15 Filed JAN 4 - 1923 ROBERT R. KRAUTEN, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 3 1923

17 I HEREBY CERTIFY, That I attended deceased from March . 1920 . to January 3 1923 .

that I last saw h alive on January 3 1923

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Thos. D. Sloan, M. D.

, 19 (Address) 7 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Jan 6 1923

20 UNDERTAKER Forbert & Forbert — ADDRESS 1739 Eager

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

159500 D70770 D70770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Baber

(a) RESIDENCE No. 3108 Barclay St. City ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 13. 1890

7 AGE — Years: 32 Months: 4 Days: 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Cook

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Walter Baber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Martha Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): JOHNS HOPKINS HOSPITAL Records

15 Filed JAN 4 - 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1922 to Jan. 3, 1923.

that I last saw her alive on Jan. 3, 1923,

and that death occurred, on the date stated above, at 3 30 A. m.

The CAUSE OF DEATH* was as follows:

Subacute Bacterial Endocarditis (Strept. Viridans)

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. H. Burns, M. D.

1/3 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Beaver Dam Station

DATE OF BURIAL: Jan 4 1923

20 UNDERTAKER: Honour & Va Mr. Robert A Elliott

ADDRESS: 1725 Ashland Av

Prompt action very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70771

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70771

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Bayview Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

2-FULL NAME Edwarde Brooks Pumphrey

(a) RESIDENCE NO. F 147 East ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Pumphrey

6 DATE OF BIRTH (month, day and year): 1875

7 AGE: Years 47 Months Days

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Eliza Derby.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Bayview Hospital Balto, Md.

15 Dec 4 1923, 19 Robert F. Curtis, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 31, 1922

17 I HEREBY CERTIFY, that I attended deceased from Nov. 25, 1922, to Dec 31, 1922

that I last saw h- alive on Dec. 31, 1922

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Terminal)

..... (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General Paralysis, Insane (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathological

(Signed) Fred N. Edwards, M. D.

....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel City — DATE OF BURIAL: 1/4 1923

20 UNDERTAKER: L. Russelburgh — ADDRESS: 2620 St Paul

IMPORTANT. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70772

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70772

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 755 Dover St.: 21 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Flowers

(a) RESIDENCE. No. 755 Dover. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Mar.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ella Flowers

(Address) 755 Dover.

15 Filed Jan 3, 1923 Robert F. Carrigan Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1922, to Jan 2, 1923,

that I last saw h... alive on Jan 2, 1923,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F Norwood, M. D.

Jan 3, 1923 (Address) 923 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 7 1923
20 UNDERTAKER	ADDRESS
Edward Ruppold	1463 N. Carey

1923

Print in ink. Write plainly. Be sure to answer every question. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Barnett)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70773

CERTIFICATE OF DEATH.

11-002 D70773

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 723 School Ln ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clubby Barnett

(Residence in Baltimore: No. 723 School St St.: 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Feb 8 (Month) (Day), 1873 (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Oil

9-BIRTHPLACE, (State or Country), Calvert County Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Calvert County

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Calvert County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Russell Barnett

(Address) 111 Winchester St

15-

Filed, 1923, Robert B. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 2 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 12/25 1922, to 1/2 1923, that I saw him alive on 1/2 1923, and that death occurred, on the date stated above, at 7 10 m.

The CAUSE OF DEATH* was as follows:

Ac. Peritonitis
Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) B. Russell Barnett M. D.

Jan 2, 1923 (Address) 2136 W. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, Jan 4, 1923

20-UNDERTAKER Edward Ringgold

ADDRESS 1463 N. Carey

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70774

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 411 N Fremont ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Bosson

(a) RESIDENCE. NO. 411 N Fremont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wht	Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo H. Bosson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Sullahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Redding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Geo H Bosson 411 N Fremont

15 Filed Jan 5 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 3, 1923, that I last saw h alive on Jan 2, 1923, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmo Congestion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Jan 5, 1923 (Address) 939 N Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	1-5-1923
20 UNDERTAKER H. C. Brammer Son	ADDRESS 517 W Schroeder St

Important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D70775

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70775

CERTIFICATE OF DEATH.

74-001

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 898 N. Howard St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Giovanna Vicari

(Residence in Baltimore: No. 818 N. Howard St.; 60 yrs., 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, unknown (Month), (Day), 1853 (Year)

7-AGE, 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Varesti

(Address) 811 Edmondson Ave

15-

Robert P. Harrison,

Filed....., 191.....

4-1923 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 3, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1922, to Jan. 3, 1923, that I saw her alive on Jan. 2, 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY Interstitial Nephritis

(Secondary) (Duration) 1 yrs. mos. ds.

(Signed) E. L. Passano M. D.

Jan. 3, 23 (Address) Tan Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral — DATE OF BURIAL, 1-5-, 1923

20-UNDERTAKER H. C. Brauning & Son — ADDRESS 511 N. Edmondson Av.

D70776 **HEALTH DEPARTMENT--CITY OF BALTIMORE** D70776

CERTIFICATE OF DEATH 91-002

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 2625 St Paul St. 12 ST.; WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Deana West

(Residence in Baltimore: No. 2625 St Paul St.; 60 yrs. 10 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Feb 9 - 1844, 1 (Month) (Day) (Year)

7 AGE: 78 yrs. 10 mos. 24 ds. | If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Va

PARENTS

10 NAME OF FATHER: Edward C. Williams

11 BIRTHPLACE OF FATHER (State or country): Va

12 MAIDEN NAME OF MOTHER: Jane King

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm J West
(Address) 2625 St Paul St

15 Filed ..., 191 — REGISTRAR: Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January 3rd, 1913 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1912, to Jan 1st 1913, that I saw h.. alive on Jany 1st, 1913, and that death occurred, on the date stated above, at 7 A.m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

(Duration) ... yrs. ... mos. ... ds
Contributory (SECONDARY) Cystitis (Duration) 6 mos yrs. ... mos. ... ds.
(Signed) Wm T. Lockwood M. D.
Jan 4, 1913 (Address) 5 E. Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Greenmount Cem. | DATE OF BURIAL: Jan 5, 1913

20 UNDERTAKER: Chas E. Franck | ADDRESS: 802 Madison

25 very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70777 ✓ D70777

D70777

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Inf. REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

2-FULL NAME Katherine Hobgen

(a) RESIDENCE NO. Church Home ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gravatt Hobgen

6 DATE OF BIRTH (month, day, and year) Jan 28-1850

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
72.	11	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER George B. Wade

11 BIRTHPLACE OF FATHER (city or town) England (State or country)

12 MAIDEN NAME OF MOTHER Miss Sutherland

13 BIRTHPLACE OF MOTHER (city or town) Eng (State or country)

14 Informant Church Home Infirmary (Address) Robert F. Haviland

15 Filed ..... 19 ..... Registrar Burial Permit Clerk

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1922, to Jan 4, 1923, that I last saw h[illegible] alive on Jan 3, 1923, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Cayetano Canettieri M. D.

, 19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL Jan 5 1923

20 UNDERTAKER John Oursler ADDRESS 1301 W. Fayette

Sec. 3 of Act requires prompt. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70778 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D70778

CERTIFICATE OF DEATH. X 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary W. Worthington

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Mr Worthington

6 DATE OF BIRTH (month, day, and year) Dec. 23-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Balto Co Md-

PARENTS

10 NAME OF FATHER Noah H. Worthington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md-

12 MAIDEN NAME OF MOTHER Mary Ann (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant (Address) Record of Mt Hope Retreat Baltimore Md

15 Filed . 19 Registrar

1923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 8th, 1922, to Jan 3rd, 1923, that I last saw h[illegible] alive on Jan 2nd, 1922, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes

abt (duration) 6 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Pneumonia Bronchial - abt (duration) 5 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Co Md-

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? ———

(Signed) Frank J Flannery, M. D.

Jan 3rd 1923 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 1/5/1923

20 UNDERTAKER: John O. Mitchell, 1201 W Fayette St

ADDRESS

D70779

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70779

CERTIFICATE OF DEATH.

188-003

REGISTERED No. C.....

1 PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE (No. Albion Hotel ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Alexander Mc-Kim

(Residence in Baltimore: No. Read & Cathedral St

St.; 17 yrs., 5 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 23 (Day) 1905 (Year)

7-AGE, 17 yrs. 5 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Gilman Country
(b) General nature of industry, business, or establishment in which employed (or employer)..... School Student

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, J Sterett Mc-Kim

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary H Tuckes

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Sterett Mc-Kim

(Address) Hotel Albion Read & Cathedral Sts

15-

1923 ..... 191.....

Registrar.

Robert E. Garrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 2, (Month) (Day) 1923 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner's (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(Duration).....yrs.....mos.....1.....ds.

CONTRIBUTORY (Secondary) automobile accident

(Duration).....yrs.....mos.....ds.

(Signed) J. C. Hemmeter M. D.
(Coroner.)

Jan. 3, 1923 (Address) 700 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem. DATE OF BURIAL, January 5 1923

20-UNDERTAKER Henry H Jenkins Sons Co. ADDRESS Orchard & Mc-Culloh Sts

Spec.—1-10-21—M&T—1500 Bks.

(J Haeffner)

D70780

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70780

CERTIFICATE OF DEATH.

139

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST. 19 WARD)

2-FULL NAME Catherine Haeffner

(a) RESIDENCE NO. Lansdowne, Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of John Haeffner

6 DATE OF BIRTH (month, day, and year) Feb 14 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

139

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Md

PARENTS

10 NAME OF FATHER Adam Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Gravesdafer

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Mr. John Haeffner

(Address) Hazelhurst Ave Lansdowne Balto

15 Filed ....., 19 ..... Registrar

1923

ROBERT P. HARRISON

Burial Permit & Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 3 - 1923

17

I HEREBY CERTIFY, That I attended deceased from 12-31- , 19 22 , to 1 - 3 - , 19 23 ,

that I last saw her alive on 1 - 3 - , 19 23 ,

and that death occurred, on the date stated above, at 5:14 p m.

The CAUSE OF DEATH* was as follows:

Multiple Fibroids of uterus

(duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial degen

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 1-2-23

Was there an autopsy? no

What test confirmed diagnosis? Op. findings & symptoms

(Signed) Newton Love, M. D.

1 , 19 23 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Jan 6 1923

20 UNDERTAKER: Jos Joerdens & Son

ADDRESS: 2178 N.

4

HOW IS very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70781

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D70781

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore Md

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2636 Bernard ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence D. Leister Jr

(a) RESIDENCE. No. 2636 Bernard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 2/1922.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Clarence D. Leister Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Blanche Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Clarence D Leister sr.

(Address) 2637 Bernard St.

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3. 1923

17 I HEREBY CERTIFY, That I attended deceased from December 23. 1922. to January 3. 1923.

that I last saw h in alive on Jany 3. 1923.

and that death occurred, on the date stated above, at 11 25 P. m.

The CAUSE OF DEATH* was as follows:

Bronchs-pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) None -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) W Ingram, M. D.

1/4. 1923 (Address) 2737 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Hill Balti Co	1/5 1923
20 UNDERTAKER	ADDRESS
Walter Davis	3307 Pine St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70782

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70782

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH University Hospital.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard + Greene. ST.: 22 WARD)

2-FULL NAME Joseph Jasinski

(a) RESIDENCE. NO. 539 S. Paca St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood-worker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Roch. Jasinski

11 BIRTHPLACE OF FATHER (City or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Caroline Kacperek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant (Address) Widow 2008 Bank St

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/2 1923

17 I HEREBY CERTIFY, That I attended deceased from 10/10, 1922, to 1/2, 1923,

that I last saw him alive on 1/2, 1923

and that death occurred, on the date stated above, at 9 55 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) Aron Freedom, M. D.

1/2, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: 1/4 1923

20 UNDERTAKER: William F. Kaelber & Co. ADDRESS: 168 Eastern

Burial Permit Given

Robert P. Carlson,

1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70783

CERTIFICATE OF DEATH.

D70783

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jacobs

(a) RESIDENCE NO. Bartonsville, Frederick, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6 1/2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Elmer Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed , 19 Registrar

1923

American Exp.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1922, to Jan 3, 1923

that I last saw him alive on Jan 3, 1923

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Furunculosis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brunswick Md.

DATE OF BURIAL: 1-4 1923

20 UNDERTAKER: E & B Hurle.

ADDRESS: 145 E Broadway

Fill in all items. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70784

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70784

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 840 W. Fayette ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary R. Tyson

(a) RESIDENCE. NO. 840 W. Fayette St ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. ds. How long in U. S., If of foreign birth? — yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Joshua J. H. Tyson

6 DATE OF BIRTH (month, day, and year): June 21-1842

7 AGE: Years 80 | Months 6 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Jersey

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Jersey

14 Informant (Address): Hattie G. Tyson 840 W. Fayette St.

15 Filed . 19 Registrar

923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, . 1922, to Jan 3rd, . 1923.

that I last saw her alive on Jan. 3rd. 1923.

and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 2 yrs. — mos. ds.

CONTRIBUTORY (Secondary): Age, infirmaties

(duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. M. Tannebaker, M. D.

. 19 (Address) 209 Madison ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Jan 5 1923

20 UNDERTAKER: Geo. J. Smith ADDRESS: 1532 Hollins St

Spec.—1-10-21—M&T—1500 Bks.

D70785

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 ✓ D70785

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1424 Carroll ST. 21 WARD)

2-FULL NAME Henry Benner

(a) RESIDENCE NO. 1424 Carroll ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of May Benner

6 DATE OF BIRTH (month, day, and year) March 15-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter 075

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William E. Benner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna E Funk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles E Benner (Address) 1759 Darley Ave

15 Filed 1923 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1922, to Jan 2, 1923.

that I last saw h— alive on Jan 1, 1923.

and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eden Symington, M. D.

1/3, 1923 (Address) 517 Lenox

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 1/5 1923

20 UNDERTAKER Wm. Cook

ADDRESS 542 E Fayette Ave

Deputy Health Officer.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70786

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70786

CERTIFICATE OF DEATH.

22 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 S. Fremont ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Hardesty

(a) RESIDENCE. No. 617 S. Fremont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie E. Hardesty

6 DATE OF BIRTH (month, day, and year) Sept 15-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fisherman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert County Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Annie E. Addison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert County Md.

14 Informant John W. Hardesty (Address) 330 St Helena ave

15 Filed . 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 2 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 30, 1922, to Jan 1, 1923, that I last saw him alive on Jan 1, 1923, and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

1/3, 1923 (Address) 733 Arsquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. W. Ox Ch

DATE OF BURIAL. Jan 5 1923

20 UNDERTAKER

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

Margaret Boyd
25 N Barclay

D70787

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D70787

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 329 N. Fulton ST. 19 (WARD)

2-FULL NAME Margaret Misell

(a) RESIDENCE NO. 329 N. Fulton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed or Divorced, (write word) Widowed

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Geo. M. Misell

6 DATE OF BIRTH (month, day, and year) Feb 28. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Wife Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS
10 NAME OF FATHER John H. Green
11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania
12 MAIDEN NAME OF MOTHER Ann Sperry
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Geo M. Misell
(Address) 329 N. Fulton

15 Filed ..... 19 ..... Registrar
Robert F. Harrison
1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 25th, 1922, to Jan 3rd, 1923.
that I last saw her alive on Jan 3rd, 1923
and that death occurred, on the date stated above, at 2.30 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) La Grippe.
(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) [illegible] M. D.
1/4/23 (Address) 401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 1/6 1923

20 UNDERTAKER William Cook — ADDRESS 502 E Mt

FROM is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Dawes

D70788

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D70788

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Linden ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Naeve

(a) RESIDENCE No. 1614 Linden ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Detlef Naeve

6 DATE OF BIRTH (month, day, and year) 12-21-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gutstown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gutstown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Detlef Naeve
(Address) 1614 Linden Ave

15 Jan 5 1923 . 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 3 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 3, 1923, that I last saw her alive on Jan 3, 1923 and that death occurred, on the date stated above, at 4 30 0 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Hardening of Arteries

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R H Dawes, M. D.

, 19 (Address) 1509 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 1/5 1923

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

How is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70789 D70789

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1905 Chelsea Road ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth B. Mathews

(a) RESIDENCE NO. 1905 Chelsea Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	— Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 6th, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	54	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Public Schools.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wilbur F. Mathews.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Martinsburg W. Va.

12 MAIDEN NAME OF MOTHER Mary J. Bride

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant James S. Mathews

(Address) 1905 Chelsea Road

15 Filed 1923 . 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3rd. 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 20. 1922 to Jany 3rd. 1923.

that I last saw her alive on Jany 3rd. 1923.

and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

of about

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cancer of Breast - Carcinoma - Lymphatics - undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Carcinoma in Aug. 1922

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Eleanor C. Price, M. D.

1-4, 1923 (Address) 1012 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL Jan 6th, 1923

20 UNDERTAKER Bertram D. Gore

ADDRESS 1237 N. Eutaw St.

Please keep very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

(Staszewski)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70790

11-02 D70790

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 S. Castle St.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Teodor Staszewski

(Residence in Baltimore: No. 322 S Castel St.: ....yrs.,....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) X

6-DATE OF BIRTH, November 3, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Nicholaus Staszewski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Apolonia Jaralski

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicholaus Staszewski

(Address) 322 S castel

15-

Robert P. Harrison,
Burial Permit Clerk, Registrar.

Filed ..... 191.....

1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 4, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1923 to Jan 4 1923, that I saw h in alive on Jan 3 1923, and that death occurred, on the date stated above, at 3/1 .m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ....yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) & Meningeal symptoms &

(Duration) ....yrs. ....mos. ....ds.

(Signed) E. J. Starr M. D.

Jan 4, 1923 (Address) 811 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary | DATE OF BURIAL, Jan 5, 1923

20-UNDERTAKER John M Weber | ADDRESS 1803 Bank St

D70791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70791

181-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3736 Roland Ave. ST. 13 (WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Austin E. Armiger

(Residence in Baltimore: No. 3736 Roland Ave. S. 30 yrs., 4 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Single

6-DATE OF BIRTH: Aug. (Month) 17 (Day), 1892 (Year)

7-AGE: 30 yrs. 4 mos. 16 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist Helper
(b) General nature of industry, business, or establishment in which employed (or employer): Poole & M. Co.

9-BIRTHPLACE (State or Country): Baltimore, Md.

PARENTS:

10-NAME OF FATHER: John F. Armiger

11-BIRTHPLACE OF FATHER (State or Country): Baltimore, Md.

12-MAIDEN NAME OF MOTHER: Sarah E. Bull

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Sarah E. Bull

(Address) 3736 Roland Ave.

15- Robert P. Harrison, Burial Permit Clerk.

Filed ..... 191 .....

1923 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jan. (Month) 2 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) was of opinion that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Gas from open grate accidental

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F. Armiger M. D. (Coroner.)

Jan. ..., 1923 (Address) 3622 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL: Woodlawn

DATE OF BURIAL: Jan. 5..., 1923

20-UNDERTAKER: Horace H. Burgee

ADDRESS: 363 Gallow Rd

David G. Butcher

Spec.—1-10-21—M&T—1500 Bks.

D70792

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70792

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD 12)

2-FULL NAME David G. Butcher

(a) RESIDENCE NO. 2621 Huntingdon Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia L. Butcher

6 DATE OF BIRTH (month, day, and year) Feb. 24 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn'a Town, Penn'a

PARENTS

10 NAME OF FATHER Jacob Butcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn'a

12 MAIDEN NAME OF MOTHER Margaret Hammitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn'a

14 Informant Mrs. Geo. P. Stiles

(Address) 2621 Huntingdon Ave

15 Filed 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1923, to Jan 4, 1923, that I last saw h[illegible] alive on Jan 3, 1923, and that death occurred, on the date stated above, at 3:50 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum + Sugar

(Signed) [illegible] M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Jan 6 1923

UNDERTAKER Horace H. Burgee

ADDRESS 663 Hollins St.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70793

CERTIFICATE OF DEATH.

108-00 D70793

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 346 S. Stricker ST.. 19 WARD)

2-FULL NAME Josephine J. Odem

(a) RESIDENCE. NO. 346 S. Stricker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Odem (Deceased)

6 DATE OF BIRTH (month, day, and year) Aug 6 - 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeping

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Harding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Geo Seymour (Address) 800 W. Barre St.

15 Filed . 19 Registrar

1923 Robert F. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 21 . 1922 . to Jan 3 . 1923.

that I last saw her alive on Jan 2 . 1923.

and that death occurred, on the date stated above, at 9.15 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(duration) ✓ yrs. ✓ mos. 14 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Odem M. D.

Jan 3 1923 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Savage Md	1/5/23 19
20 UNDERTAKER	ADDRESS
Jos Forrest	Laurel Md

THIS is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks

(Samuel Wagner)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70794

D70794

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2447 Barclay St. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Saml Wagner

(a) RESIDENCE. NO. 2447 Barclay ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Wagner

6 DATE OF BIRTH (month, day, and year) Sept 23 1831

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	91	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Michael Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Weaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Caroline Wagner

(Address) 2442 Barclay

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922, to Jan 3, 1922, that I last saw h. alive on Jany 2, 1922, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W Thistel M. D.

, 19 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Meadow Branch Cemetery	Jan 5 1922
20 UNDERTAKER	ADDRESS
W M Rouleon	2238 N Monroe

Registrar

D70795

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D70795

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 22 Bayonne ave St., Hamilton 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Francis Sudusan

(Residence in Baltimore: No. 2904 Canterbury Rd St., 33 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

6-DATE OF BIRTH, July 18 1857 (Month) (Day) (Year)

7-AGE, 70 yrs. 5 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). New Foundland

PARENTS.

10-NAME OF FATHER, John Shea

11-BIRTHPLACE OF FATHER (State or Country). New Foundland

12-MAIDEN NAME OF MOTHER, Mary —

13-BIRTHPLACE OF MOTHER, (State or Country), New Foundland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jos A. Gallagher

(Address) 2904 Canterbury Rd

15- Robert F. Harrison, Filed ..... 192 ..... Registrar. Harold Ferdt Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 2 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed) J. H. Collins M. D. (Coroner.)

1-4 1923 (Address) 508 E. Lanvale

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral	1/5 1923
20-UNDERTAKER. John A Moran	ADDRESS 3008 E. Balto.

Spec.—1-10-21—M&T—1500 Bks.

D70796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D70796

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 N Patterson Park Ave St., 6 WARD)

2-FULL NAME John Thomas Sturgeon

(a) RESIDENCE NO. 206 N Patterson Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~or) WIFE of~~ Husband of Jean Louisa Sturgeon

6 DATE OF BIRTH (month, day, and year) Jan. 31 1841

7 AGE: Years 81 Months 11 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 886

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country): North East Md

PARENTS

10 NAME OF FATHER Thomas Sturgeon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Martha Redgrave

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Walter C Bacon 100 E 20th St Balto. Md

15 Filed JAN 7 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/3/23 19

17 I HEREBY CERTIFY, That I attended deceased from ..., 1918, to Jan 3, 1923.

that I last saw him alive on Jan 2, 1923

and that death occurred, on the date stated above, at 6.45 a m

The CAUSE OF DEATH* was as follows:

Ch. Interstitial Nephritis

(duration) 2 + yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Thos of Nephritis

(Signed) Walter C Bacon, M. D.

, 19 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 1/5 1923

20 UNDERTAKER: John A. Moran 3000

ADDRESS: E. Baltimore St

From a very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D70797

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70797

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hosp

CITY OF BALTIMORE: (No. Eastern Ave ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Haskins

(a) RESIDENCE NO. 627 W. Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H W.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER David Gregory

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mathes Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Municipal Hosp. Record

(Address)

15 Filed ....., 19 .....

Registrar

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 1 1923

17

I HEREBY CERTIFY, That I attended deceased from 12-11, 1922 to 1-1, 1923.

that I last saw her alive on 1-1, 1922,

and that death occurred, on the date stated above, at 11:15 A m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma of glands neck, axilla, Hodgkin's disease & inguinal glands.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Micro. of gland.

(Signed) J. Richardson Johnson M. D.

1-1, 1923 (Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chase City Va

DATE OF BURIAL 1/5 1923

20 UNDERTAKER Jno Gross Hooper & Co

ADDRESS 40 W Lanvale St

ROBERT F. DAFFRON, [illegible]

See instructions on back of certificates.

D70798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70798

CERTIFICATE OF DEATH.

6 179

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. South Baltimore General Hospital. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... George Tysom.

(Residence in Baltimore: No. 2110 East Fayette St. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White	Married.

6-DATE OF BIRTH. Do not know. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
58 yrs. -- mos. --- ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): Savage Transfer Co.

9-BIRTHPLACE, (State or Country). Pennsylvania.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jones. (niece).

(Address) 1947 N. Patterson Park Ave.

15-

Filed ..... 192.....

1923

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 3rd. 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental burns about the face. Explosion of Alcohol.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) Otto K. Reinhardt M. D. (Coroner)

Jan. 4, 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Savage Transfer Co office. Race St.

Former or usual residence December 20. 1922.

19-PLACE OF BURIAL OR REMOVAL. London Park Cem. DATE OF BURIAL. June 5 1923

20-UNDERTAKER. Wm Cook ADDRESS 502 E. North Ave

Spec.—1-10-21—M&T—1500 Bks.

D70799

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70799

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 W. Hamburg St. ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Young

(a) RESIDENCE NO. 1110 W. Hamburg St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Young

6 DATE OF BIRTH (month, day, and year) May 28" 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	72	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chambersburg (State or country) Pa.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John B. Young (Address) 1110 W. Hamburg St.

15 Filed ....., 19.... Registrar

No. 192

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 2" 19 23

17

I HEREBY CERTIFY, That I attended deceased from Dec 30, 19 22, to Jan 2, 19 23, that I last saw h[illegible] alive on Jan 1st, 19 23, and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 2 yrs. 0 mos 4 ds.

CONTRIBUTORY (Secondary) Senile Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? —

(Signed) Edw Gruenbaum, M. D.

1/2 19 23 (Address) 517 Scott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL Jan 5" 19 23

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 W. Balto

Robert P. Garrison? Clerk.

Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70800 HEALTH DEPARTMENT—CITY OF BALTIMORE D70800

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 608 W. Dolphin St.

REGISTERED NO.....

CITY OF BALTIMORE: (No. 608 W. Dolphin St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dennis Wilson

(a) RESIDENCE. NO. 608 W. Dolphin ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Martha Wilson

6 DATE OF BIRTH (month, day, and year) Feb 1st 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Princess Anne. Somerset Co. Md.

PARENTS

10 NAME OF FATHER Wm. Oliver Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Princess Anne Md.

12 MAIDEN NAME OF MOTHER Sophie Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Princess Anne Md.

14 Informant (Address) Wm. O. Wilson 608 W. Dolphin St.

15 Filed JAN 5 - 1923, 19.... ROBERT R. KRAUTER (Registrar) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/2 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/30, 1922, to 1/2, 1923, that I last saw him alive on 1/2, 1923, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) Leon Mendon M. D.

1/3, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 1/5 1923

20 UNDERTAKER Samuel Wensley

ADDRESS 1128 W Balto

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70801

CERTIFICATE OF DEATH.

74-001 D70801

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 834 Sloan ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Peters

(a) RESIDENCE No. 834 Sloan ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ..min.
65				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) same 044

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Simon Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Libbie Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Annie Death

(Address) 834 Sloan St

15 Filed JAN 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1922 to Jan 4, 1923

that I last saw h alive on Jan 4, 1923,

and that death occurred, on the date stated above, at 9:45 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Diffuse artero sclerosis unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Fotheringe M. D.

1/4, 1923 (Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	1/6 1923
UNDERTAKER Samuel D Kemsley	ADDRESS 512 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

D70802

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70802

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH South Balto Gen Hospital

CITY OF BALTIMORE: (No. 1211 Light St., 24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Saf or zaslowsky

(a) RESIDENCE No. 83 Dundalk ave, Dundalk St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2 1923

7 AGE: Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Zaslowsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie Frankel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Balto

15 Filed JAN 5 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 3 1923

17 I HEREBY CERTIFY, That I attended deceased from January 3 1923 to January 3 1923

that I last saw him alive on January 3 1923

and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) 0 yrs. 0 mos 1 ds.

CONTRIBUTORY (Secondary) Breech Presentation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A Colmore M. D.

1923 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Workmen circle Cem — DATE OF BURIAL: 1/4 1923

20 UNDERTAKER: Jack Lewis 1439 E Balto — ADDRESS

Note is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70803 HEALTH DEPARTMENT—CITY OF BALTIMORE D70803

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 302 N Exeter St., 5 WARD)

2-FULL NAME Dora Riva Fisher

(a) RESIDENCE No. 302 N Exeter St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 17 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Fisher

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Bear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie Bear

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1+39 E. Baltimore

15 Filed JAN 5 - 1923 19.. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1922, to January 4, 1923, that I last saw h alive on January 4, 1923, and that death occurred, on the date stated above, at 9:20 P m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) senile asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. S. Tobkeleman, M. D.

1/5, 1923 (Address) 1576 N Bentalou st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Rose Md

DATE OF BURIAL Jan 5 1923

20 UNDERTAKER Jas Lewis

ADDRESS 1+39 E Balto

Sec. 3 Supplement. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70804

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70804

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 330 Gwynn Ave. WARD) 20

2-FULL NAME Susie K. Jones

(a) RESIDENCE NO. 330 Gwynn Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of: Wm. Jones

6 DATE OF BIRTH (month, day, and year): Jan 31 1848

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
74	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER: Charles E. Buckingham

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Mary S. Hagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Eugene C Buckingham

(Address): 330 Gwynn Ave

15 Filed JAN 5 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 25 1922 to Jan 4 1923.

that I last saw h... alive on Jan 2 1923,

and that death occurred, on the date stated above, at 5-P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm G. Queen, M. D.

JAN 4 19 1923 (Address) 350 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: London Park

DATE OF BURIAL: JAN 6 1923

20 UNDERTAKER: Geo N Little

ADDRESS 2700 EDMONDSON AVE

ATION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70805

CERTIFICATE OF DEATH.

90 D70805

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3305-Windsor Mill Road ST., 15 WARD)

2-FULL NAME ADA AUGUSTA GOTT

(a) RESIDENCE NO. 3305-Windsor Mill-Road ST. 15 WARD (Resident)
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 85 yrs. 2 mos. 12 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) Oct-22-1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	85	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto.Co.,Md. Maryland

PARENTS

10 NAME OF FATHER John Robert Gott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.Co. Maryland

12 MAIDEN NAME OF MOTHER Mary Coale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.Co. Maryland

14 Informant Miss Ada M. Andrews (Niece)

(Address) 3305-Windsor-Mill-Road.

15 Filed JAN 5 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to Jan 3, 1923, that I last saw h- alive on Jan 3, 1923, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Myocarditis - arteriosclerosis

Hypostatic (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted ——
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Thos S Gilbert, M. D.

Jan 3, 1923 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL LOUDON PARK CEMETERY

DATE OF BURIAL Jan-3-23

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70806

D70806

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

2-FULL NAME Edwin C. Fields, Sr.

(a) RESIDENCE. NO. 2138 E. 24th St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Watkins Fields

6 DATE OF BIRTH (month, day, and year) May 28, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69 yrs.	7 mos	7 ds.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Fertilizer Plant

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Daniel Fields

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y. City.

12 MAIDEN NAME OF MOTHER Harriett Priscilla Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co., Md

14 Informant (Address) Roberta Fields Carter 2024 Brookfield Ave City.

15 Filed JAN 5 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1922 to Jan. 4, 1923, that I last saw h[illegible] alive on Jan. 4, 1923, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Gangrene
(Rgld foot + Leg.

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory

(Signed) T C B Jones, M. D.

1/4 19 22 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Federal Hill Md	Jan 6 1923
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

D70807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70807

CERTIFICATE OF DEATH.

Registered No. C 185 6

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby 6 Saunders

(Residence in Baltimore: No. 225 N. Kenwood St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) W

6-DATE OF BIRTH. Aug (Month) 17 (Day) 1845 (Year)

7-AGE. 79 yrs. 4 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Louis Schmidt

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. John Baltes

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Arthur Creamer

(Address) 225 N. Kenwood

15-

Filed JAN 5 1923 192 ROBERT R. REITZEL Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan (Month) 3 (Day) 192? (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull
accidental - Fell down stairs
slips at 225 N. Kenwood

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) J. S. Collier M. D. (Coroner.)

1-4-23 192 (Address) 506 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Balto Cemetery

DATE OF BURIAL. Jan 5 1923

20-UNDERTAKER. John Ellerich

ADDRESS 2008 Orleans

Spec.—1-10-21—M&T—1500 Bks.

D7080 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D7080

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital. ST., [illegible] WARD)

2-FULL NAME Angie Hammond

(a) RESIDENCE NO. Bay View Hospital. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Waite	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 7 [illegible], 1916, to January 3, 1923.

that I last saw her alive on January 3, 1923.

and that death occurred, on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Idiopathic epilepsy

(duration) 7 yrs. 11 mos ..... ds.

CONTRIBUTORY (Secondary) Senility

(duration) 10 yrs. mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Clyde M. O'Neill, M. D.

1/4/19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Jan 5 1923

20 UNDERTAKER Harry H. Witzke

ADDRESS 1530 W. Lombard St.

(1) Name and surname of deceased. (2) Date of death, as month, day and year. (3) Sex. (4) Color—whether white, black, mulatto, Chinese, Indian, or other nonwhite race. (5) Whether single, married, widowed, or divorced. (6) Date of birth, as month, day and year. (7) If less than one day, hours or minutes. (8) Occupation. (9) Birthplace. (10) Name of father. (11) Birthplace of father. (12) Maiden name of mother. (13) Birthplace of mother. (14) Informant. (15) Filed. (16) Date of death. (17) Cause of death. (18) Where disease contracted. (19) Place of burial, cremation or removal. (20) Undertaker. (21) Address of undertaker.

See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70809

HEALTH DEPARTMENT—CITY OF BALTIMORE

89

D70809

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marlborough apts ST., 14 WARD)

2-FULL NAME Mollie Newhoff

(a) RESIDENCE NO. Marlborough apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Newhoff

6 DATE OF BIRTH (month, day, and year) Oct 7 - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Abraham Lehman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Miss Strauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Morton L. Newhoff (Address) Marlborough apts

15 Filed JAN 5 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 11 1923

17

I HEREBY CERTIFY, That I attended deceased from January 22, 1922, to Jany 3, 1923, that I last saw h alive on Jany 3, 1923, and that death occurred, on the date stated above, at 11 50 P m.

The CAUSE OF DEATH* was as follows:

Angina pectoris (Coronary artery thrombosis)

(duration) — yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) Aortic insufficiency

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) James P Hausbergers, M. D.

Jany 4, 1923 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chet Sholom Cem.

DATE OF BURIAL 1/5 19 23

20 UNDERTAKER David Sondheim ADDRESS 1187 W. Lexington

Instructions: See instructions on back of certificates.

RECEIVED H. R. KRAUTER JAN 5 1923 CITY REGISTRAR

D70810

HEALTH DEPARTMENT—CITY OF BALTIMORE

66

D70810

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1807 Maryland Ave ST. 12 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John DeKersey

(Residence in Baltimore: No. 20 E. 20th St.; 23 years St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug 24 (Month) (Day) 1890 (Year)

7-AGE, 44 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Yards

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER, Dick DeKersey

11-BIRTHPLACE OF FATHER (State or Country), Gloster Co Va

12-MAIDEN NAME OF MOTHER Martha Scott

13-BIRTHPLACE OF MOTHER (State or Country) Gloster Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary DeKersey

(Address) 20 E 20th St

15-

Filed ..... 1923 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 2 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage

Pneumonia Fibroid Lung

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas T. Riley M. D.
(Coroner.)

Jan 2, 1917 (Address) 1039 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, Jan 5, 1917

20-UNDERTAKER Wm Robert & Elliott

ADDRESS 1715 Aisland Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70811

CERTIFICATE OF DEATH.

74-001

D70811

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Brown

(a) RESIDENCE NO. 1003 Salisbury Court. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 65 ?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 5 - 1923, 19 ROBERT R. KRAUFER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1 19 23

17

I HEREBY CERTIFY, That I attended deceased from December 29, 19 22 to January 1, 19 23.

that I last saw her alive on December 31, 19 22.

and that death occurred, on the date stated above, at 3:00 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 65 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Marvin M. D.

Jan. 19, 23 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 1/4 1923

20 UNDERTAKER

ADDRESS

Commissioner of Health.

Dr. P. E. Wessel

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70812

CERTIFICATE OF DEATH.

100-001
D70812

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. St. Elizabeths' Home ST.; 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jeanette Griffin

(Residence in Baltimore: No. St. Elizabeths' Home St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, June (Month) 22 (Day), 1919 (Year)

7-AGE, 3 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Herman Griffin

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Laura Lawson

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-
Filed JAN 5 - 1923, 191...
ROBERT R. KRAUTER,
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 2 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 20 1922, to January 2 1923 that I saw h[er] alive on January 2 1923 and that death occurred, on the date stated above, at 11P. m.

The CAUSE OF DEATH* was as follows:

Ileo-colitis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 7 ds.

(Signed) Frank J. Ayd, M. D.

Jan 3, 1923 (Address) 2005 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 1/4, 1923

20-UNDERTAKER ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner of Health.

0015

Spec.—1-10-21—M&T—1500 Bks.

D70813

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-003

D70813

REGISTERED NO.

1-PLACE OF DEATH Homewood Hospital

CITY OF BALTIMORE: (No. 2724 N. Charles ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lochte.

(a) RESIDENCE NO. 324 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 4-1923

7 AGE	Years	Months	Days	If LESS than 1 day, 3½ hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 2724 N. Charles St. Baltimore

PARENTS

10 NAME OF FATHER Bernard Lochte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Barbara Rundle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Barbara Lochte (Address) 324 Eastern Ave.

15 Filed JAN 5-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923, to Jan 5, 1923, that I last saw him alive on January 4, 1923, and that death occurred, on the date stated above, at 12 55 a. m.

The CAUSE OF DEATH* was as follows:

Morbus carrulens

(duration) yrs. ½ mos. hours ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physagnos

(Signed) H. B. Friedman, M. D.

, 19 (Address) 2631 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 1/5 1923

20 UNDERTAKER Philip Hennig

ADDRESS 2016 Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70814 D70814

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1408 N. Montford St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Sichert

(Residence in Baltimore: No. 1408 N. Montford St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Widow

6-DATE OF BIRTH: Oct (Month) 11 (Day) 1848 (Year)

7-AGE: 74 yrs. 2 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Smith Stepdaughter

(Address) 1408 N. Montford

15-

Filed JAN 5 - 1923 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 3 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Collins M. D. (Coroner.)

1-4 1923 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Balto Cem. DATE OF BURIAL: 1/6 1923

20-UNDERTAKER: Philip Henry ADDRESS 2016 Orleans

Spec.—1-10-21—M&T—1500 Bks.

✓ D70815

HEALTH DEPARTMENT—CITY OF BALTIMORE 161-0 [illegible]

D70815

CERTIFICATE OF DEATH [illegible]

1-PLACE OF DEATH, S. Balto Gen. Hosp

CITY OF BALTIMORE: (No. 1211 Light St ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Waddell

(a) RESIDENCE NO. 1610 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3 1920

7 AGE Years Months Days If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Aubrey Waddell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Interstate

12 MAIDEN NAME OF MOTHER Rebecca Farden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant (Address)

15 Filed JAN 5 - 1923 ROBERT R. KRAUTER, Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1923

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1923 to January 3, 1923

that I last saw her alive on January 3, 1923,

and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? ...c...

What test confirmed diagnosis?

(Signed) John O'Connor, M. D.

, 19 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 1/4 1923

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL Commissioner Health.

Per. Wm. H. WOOSLEY.

(OVER)

D70816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D70816

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1613 Penna Ave. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Bell Lee

(Residence in Baltimore: No. 1613 Penna Ave. St.; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Feb. 22, 1899 (Month) (Day) (Year)

7-AGE: 23 yrs. 10 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: Henry Carter

11-BIRTHPLACE OF FATHER, (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Mary Hendricks

13-BIRTHPLACE OF MOTHER, (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Zebulon Lee

(Address) 1613 Penna Ave.

15- FILED JAN 5 - 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jan. 3, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. 1 mos. ds.

(Signed) J. T. Heuisler M. D. (Coroner.)

Jan. 4, 1923 (Address) 2302 Eutaw Pl.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Olivet Cem. Lancaster & Co. DATE OF BURIAL: Jan 5 1923

20-UNDERTAKER: Sam'l H. Chase & Son ADDRESS 1406 Mosher

Spec.—8-24-14—M. & T.—2000 Bks.

Marie M Cooper

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70817

CERTIFICATE OF DEATH.

31

D70817

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie M. Cooper.

(Residence in Baltimore: No. 1814 Division St.; 23 yrs. 5 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem

4-COLOR OR RACE: Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: July (Month) 28 (Day), 1899 (Year)

7-AGE: 23 yrs. 5 mos. 6 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: John Cooper

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Maggie Cooper

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Cooper

(Address) 1814 Division St

15-

Filed JAN 5 1923, 1918 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 3 (Day), 1923 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Dec. 24 1922, to Jan 3 1923, that I saw her alive on Jan. 1 1923, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

a. Pulmonary Tuberculosis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Arthritis

(Duration) yrs. 1 mos. ds.

(Signed) H. V. Carr M. D.

Jan 5, 1923 (Address) 513 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Jan 5, 1923

20-UNDERTAKER Sam H. Frazier ADDRESS 1400 Mosher

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70818 159-002 D70818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1206 Towson Street. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Karasck.

(Residence in Baltimore: No. 1206 Towson St St.; yrs. ~~---~~ mos. ~~---~~ ds. 40 Min.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	White.	Single.

6-DATE OF BIRTH. January 3rd, 1923.
(Month) (Day) (Year)

7-AGE. ~~---~~ yrs. ~~---~~ mos. ~~---~~ ds. If LESS than 1 day, ~~--~~ hrs. or 40 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Carl Karasck.

11-BIRTHPLACE OF FATHER, (State or Country). Bohemia.

12-MAIDEN NAME OF MOTHER. Irene Toth.

13-BIRTHPLACE OF MOTHER, (State or Country). Hungary.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irene Karasck. (mother).

(Address) 1206 Towson St.

15- Filed JAN 5 - 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. January 3rd, 1923.
(Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

Jan. 4th 192 3. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Jan 7 192
20-UNDERTAKER.	ADDRESS
Frank Ewald Son	1906 E. Baltimore

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D70819

D70819

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 203 Herring Court (St.) 3 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie L. Gibbs

(a) RESIDENCE. NO. 203 Herring Court ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 ~~Single, Married, Widowed,~~ or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Gibbs

6 DATE OF BIRTH (month, day, and year): Oct 16-1881

7 AGE: Years 41 | Months 2 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: David Bishop

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant (Address): John W. Gibbs 203 Herring Court

15 Filed JAN 5-1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4-1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1922, to Jan 4, 1923, that I last saw h[e] alive on Jan 3, 1923 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Lyell Burns, M. D.

Jan 5, 1923 (Address) 22 S. Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kelford North Carolina

DATE OF BURIAL: Jan 5-1923

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Eastern Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70820

D70820

CERTIFICATE OF DEATH.

REGISTERED No. C 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Argyle ave WARD 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fergie Cook

(Residence in Baltimore No. 1014 Argyle ave St.; unknown yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... 1878 ....., 1 .....
(Month) (Day) (Year)

7-AGE, 44 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Private

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Nelson Moody

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gilbert Smith

(Address) 1014 Argyle ave

15-

Filed JAN 5 1923, 191 ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan. 3d 1923, 191 .....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 31st 1922, to Jan 3d 1923, that I saw h[er] alive on Jan. 3d 1923, and that death occurred on the date stated above, at 7:50 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) ? yrs. ..... mos. ..... ds.

(Signed) A. Fee Elder M. D.

1/4/1923, 191 (Address) 924 Wood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL, Jan 5th, 1923

20-UNDERTAKER David Eagan

ADDRESS 916 Pa ave

D70821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 159-002 D70821

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 17 E-Heath Street. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward J. Willey. Jr.

(Residence in Baltimore: No. 17 E. Heath Street. St.; yrs. ---- mos. ---- ds.) 7 days.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. November 26, 1922. (Month) (Day) 1..... (Year)

7-AGE. ----- yrs. 1 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Prince George Co. Md.

PARENTS.

10-NAME OF FATHER. Edward J. Willey Sr.

11-BIRTHPLACE OF FATHER, (State or Couutry) Baltimore Md.

12-MAIDEN NAME OF MOTHER. Olga E. Evans.

13-BIRTHPLACE OF MOTHER, (State or Country) Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lidia V. Keppler. (grandmother)

(Address) 17 E-Heath Street.

15 JAN 5 - 1923 ROBERT R. KRAUTER,

Filed ..... 192 ..... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 4th, 1923. (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. H. Feasharat M. D.
(Coroner.)

Jan. 4, 192 3. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem.	Jan 7 19....
20-UNDERTAKER,	ADDRESS
S. J. Fahey & Sons	318 Light St

Spec.—1-10-21—M&T—1500 Bks.

D70822 HEALTH DEPARTMENT—CITY OF BALTIMORE D70822

CERTIFICATE OF DEATH. 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3923 Foster Ave. ST., 26 WARD)

2-FULL NAME Mary C. Walker

(a) RESIDENCE NO. 3923 Foster Ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elmer D. Walker.

6 DATE OF BIRTH (month, day, and year): — 1891

7 AGE: Years 31; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): at home 31

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania.

PARENTS

10 NAME OF FATHER: Jacob Hark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn.

12 MAIDEN NAME OF MOTHER: Elizabeth Lotz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn.

14 Informant: Elmer D. Walker.

(Address) 3923 Foster ave.

15 Filed JAN 5 - 1923, 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10", 1922, to Jany 3", 1923.

that I last saw her alive on Jany 3", 1923,

and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb R. Athey, M. D.

Jan 4" 1923 (Address) 100 S Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem.

DATE OF BURIAL: Jan 6 1923

20 UNDERTAKER: Lilly and Zeiler

ADDRESS: 403 S. Mad

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70823

CERTIFICATE OF DEATH.

129 D70823

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 N. Durham St. ST., 6 WARD)

2-FULL NAME Anna Amrein

(a) RESIDENCE NO. 121 N. Durham St. ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Amrein

6 DATE OF BIRTH (month, day, and year): July 2 - 1841

7 AGE: Years 81 Months 6 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: John Tyerly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: George W. Wicklein (Address) 121 N. Durham St.

15 Filed JAN 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1922 to Jan 3, 1923.

that I last saw her alive on Jan 3, 1923

and that death occurred, on the date stated above, at 10.13 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Leo. Heller, M. D.

1/5/23 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: Jan 6 1923.

20 UNDERTAKER: Lilly & Zeile ADDRESS: 403 S. Wolfe St.

Directions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D70824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 D70824

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 N. Fulton ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Saml A. Harper

(Residence in Baltimore: No. 2104 N Fulton ave St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, 9th (Month) 15 (Day), 1863 (Year)

7-AGE, 59 yrs. 3 mos. 15 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: See Conser. 86
(b) General nature of industry, business, or establishment in which employed (or employer): Commission

9-BIRTHPLACE, (State or Country), Talbot County, Maryland

PARENTS.

10-NAME OF FATHER, Jno. C. Harper

11-BIRTHPLACE OF FATHER (State or Country), Talbot Co. Md

12-MAIDEN NAME OF MOTHER Rowena. Auld

13-BIRTHPLACE OF MOTHER (State or Country), Talbot Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Rowena Harrison

(Address) 1628 Ellamont ave

15- Filed JAN 5 - 1923, 191..... ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jany (Month) 4th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 31st 1922, to Jany 4th 1923, that I saw h im alive on Jany 4th 1923, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Erysipelas followed by infection

(Duration) ✓ yrs. ✓ mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia Meningitis

(Duration) ✓ yrs. ✓ mos. 3 ds.

(Signed). H. D. Hascock M. D.

Jany 5th 1923 (Address) 1812 Madison ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery

DATE OF BURIAL, 1.6....., 1923

20-UNDERTAKER George J Ruth

ADDRESS 1750 Harford ave

Spec.—1-10-21—M&T—1500 Blks.

D70825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D70825

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 N. Fremont ST., 17 WARD)

2-FULL NAME Mary C Bosson

(a) RESIDENCE NO. 411 N. Fremont ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 2nd 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Geo F Bosson

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Julia Stokard

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Geo Bosson
(Address) 411 N. Fremont St

Filed JAN 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923 to Jan 5, 1923.

that I last saw h[illegible] alive on Jan 4, 1923.

and that death occurred, on the date stated above, at 4 40 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 8 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Paul Brown M. D.

1/5, 1923 (Address) 1837 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 1-8-1923

20 UNDERTAKER H. C. Brauning Son

ADDRESS 61 W. Lexington St.

Keep in a very important place. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Harry Bowley) ✓

D70826 HEALTH DEPARTMENT—CITY OF BALTIMORE D70826

CERTIFICATE OF DEATH. 80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 East St. ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Bowley

(a) RESIDENCE. No 20 East St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 5 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nil

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Orsini Ernest

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Irene Bowley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Irene Bowley
(Address) 20 East St

15 Filed JAN 5 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 2nd, 1923, to Jan. 4th, 1923, that I last saw h alive on " " " , 1923, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jacob L. Winner, M. D.

1-5, 1923 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Jan 6 1923

20 UNDERTAKER: Edward Bryan — ADDRESS 1631 Orleans St

INSTRUCTIONS ON BACK OF CERTIFICATE.

D70827

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 D70827

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 210 Brookfield Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Harriet W. Strobel

(Residence in Baltimore: No. 210 Brookfield Ave 24 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F.

4-COLOR OR RACE: W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6-DATE OF BIRTH: Nov. 3, 1898 (Month) (Day) (Year)

7-AGE: 24 yrs. 2 mos. 1 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Asst Manager
(b) General nature of industry, business, or establishment in which employed (or employer):

PARENTS.

9-BIRTHPLACE, (State or Country): Balto Md

10-NAME OF FATHER: F. W. Strobel

11-BIRTHPLACE OF FATHER (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Rebecca Lee Brown

13-BIRTHPLACE OF MOTHER (State or Country): Washington D. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. W. Strobel

(Address) 210 Brookfield Ave

15- Jan 3 1923

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jan 4, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Gas Poisoning

Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert P. Harrison M. D. (Coroner.)

Jan 4 1923 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL: Washington D. C. | DATE OF BURIAL: Jan 7, 1923

20-UNDERTAKER: John D. Mitchell | ADDRESS: 120 W. Fayette St

Spec.—1-10-21—M&T—1500 Bks.

D70828

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70828

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 821 N. Fremont ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane E Clark

(a) RESIDENCE NO. 821 N. Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single~~ Married, Widowed, or ~~Divorced~~ (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. Spencer Clarke

6 DATE OF BIRTH (month, day, and year) May 1 1853

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hampton Va

PARENTS

10 NAME OF FATHER Henry N. Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rebecca Collier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Abell A. Wilson

(Address) 1217 Fremont Ave

15 1923 Jan 1 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 16 1922 to Jan 4 1923

that I last saw h-- alive on Jan 4 1923

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) Jane Broadus, M. D.

1/5 1923 (Address) 1837 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park. DATE OF BURIAL Jan 6 1923

20 UNDERTAKER Fortsam & Gore ADDRESS 1237 Lafayette Ave

Spec.—1-10-21—M&T—1500 Bks. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

H 15 Monument

D70829

HEALTH DEPARTMENT—CITY OF BALTIMORE

2900 St Paul

101-00 D70829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 Eokesbury St. Ave WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Thurman Smith

(a) RESIDENCE NO. 630 Eokesbury ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Alverta Smith

6 DATE OF BIRTH (month, day, and year) June 17-1887

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agt

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mutual Life Co

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James H. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Rosella F. Colvin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Alverta R. Smith

(Address) 630 Eokesbury St

15 Filed 1923, 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 4th 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 30th, 1922, to January 4th, 1923.

that I last saw him alive on January 4 1923

and that death occurred, on the date stated above, at 7.45 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Right Lobar)

(duration) 1 yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Worry - Depression - Debility

(duration) 1 yrs. 1 mos. 21 ds.

18 Where was disease contracted if not at place of death? ~~unknown~~

Did an operation precede death? ~~No~~ Date of

Was there an autopsy? ~~No~~

What test confirmed diagnosis?

(Signed) H. Stanley Grimsley, M. D.

Jan. 6, 1923 (Address) 900 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 1/6 1923

20 UNDERTAKER William Cook

ADDRESS 502 E North

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70830 D70830

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 26 WARD)

2-FULL NAME Benjamin F. Woodward

(a) RESIDENCE NO. Bay View Asylum. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	76	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co., Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed 5 1923, 19 Robert F. Garrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1921, to January 4, 1923, that I last saw him alive on January 3, 1923, and that death occurred, on the date stated above, at 6:30 A.M. The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. A. McCoy M. D.

1/4/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Poplar Springs Howard Co

DATE OF BURIAL 1/7 1923

20 UNDERTAKER Wm. Sloan Cook
Undertaker

ADDRESS 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

D70831

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70831

CERTIFICATE OF DEATH.

109-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 Keyser ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude A Ford

(a) RESIDENCE No. 1624 Keyser ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George H Ford

6 DATE OF BIRTH (month, day, and year): July 29/1882

7 AGE: Years 40 Months 5 Days 5 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John H Bennet

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Co

12 MAIDEN NAME OF MOTHER: Blanche Shiefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): George H Ford 1624 Keyser St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4 1923

17 I HEREBY CERTIFY, That I attended deceased from DEC 30 1922, 19 ..., to JAN 4 - 1923, 19 ...

that I last saw him alive on JAN 4 - 1923, 19 ...

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

over

(duration) X yrs. X mos. 5 ds.

CONTRIBUTORY (Secondary) Tonsillitis

(duration) X yrs. X mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Heart Blood Culture

(Signed) O. F. Decker, M. D.

1/5, 1923 (Address) 1211 E. NORTH AVE.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. DATE OF BURIAL: Jan 6 1923

UNDERTAKER: William Cook ADDRESS: 502 E North Ave

Order Burial Permit given

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70832 101-001 D70832

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 765 Ramsay ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J Burkhardt

(a) RESIDENCE. NO. 765 Ramsay ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 8 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) April 19, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lunch room

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Geo. W. Hyde

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. Burckhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER — Deichler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address) Mrs Ada R Burkhardt

15 Jan 5 1923 Robert J McKeown, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 29 1923, to Jan 5 1923, that I last saw him alive on Jan 4 1923, and that death occurred, on the date stated above, at 5-30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J M Dolerett, M. D.

Jan 5. 1923 (Address) 1621 Washington Boulevard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 8 1923

20 UNDERTAKER W. J. Tschiner & Sons ADDRESS Balto Md

Spec.—1-10-21—M&T—1500 Bks.

D70833

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70833

CERTIFICATE OF DEATH.

160-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 Norwood Rd St. Dulaney WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Stanford

(a) RESIDENCE NO. 112 Norwood Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 9 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. H. Stanford Jr

6 DATE OF BIRTH (month, day, and year) Mar 17 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Christopher Weis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bavaria

12 MAIDEN NAME OF MOTHER Harber

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bavaria

14 Informant John Harwood Stanford
(Address) 112 Norwood Rd

15 Filed , 19 1923 Registrar
Robert F. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1922 to Jan 4, 1923.

that I last saw h alive on Jan 4, 1923.

and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Hypostasis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) John H Evans M. D.

, 19 (Address) 701 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL Jan 6 1923

20 UNDERTAKER Wm J Pickerell Sons ADDRESS Govans Md

D70834 HEALTH DEPARTMENT—CITY OF BALTIMORE D70834

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1229 Hull St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Miecunski. 29

(Residence in Baltimore: No. 1229 Hull St. St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. Do not know. ..... (Month) ..... (Day) ..... 1..... (Year)

7-AGE. 46 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Lithuania.

PARENTS.

10-NAME OF FATHER, Joseph Miecunski.

11-BIRTHPLACE OF FATHER, (State or Country), Lithuania.

12-MAIDEN NAME OF MOTHER, Ksawers Ticherska.

13-BIRTHPLACE OF MOTHER, (State or Country). Lithuania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johanna Dawksza. (sister)

(Address) 641 W. Lombard St.

15-

Filed ..... 192.....

Robert P. Harrison, Registrar.

1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 4th. 1923 (Month) (Day) (Year), 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h.s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto K. Reinhardt M. D. (Coroner.)

Jan. 5th 1923 (Address) 1017 St. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	June 5 1923
20-UNDERTAKER.	ADDRESS
John Grabliauskas	425 S. Broadway St.

Spec.—1-10-21—M&T—1500 Bks.

D70835

HEALTH DEPARTMENT—CITY OF BALTIMORE

159 D70835

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 N. Lakewood ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Rines

(a) RESIDENCE NO. 207 N. Lakewood ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Samuel J Rines

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Beulah Loudenslager

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Samuel J Rines
(Address) 207 Lakewood

15 Filed ....., 19.....
Robert F. Garrison,
Registrar
1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 19 23

17 I HEREBY CERTIFY, That I attended deceased from Dec 31 19 23 to Jan 5 19 23,
that I last saw he alive on Jan 4 19 23
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows:

Convulsions.

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Congenital Malformation of Heart

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. H. Freyer Jr. M. D.

1/5, 19 23 (Address) 2638 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Lutheran Cemetery	Dec 6th 1922
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

Keep in very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70836

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70836

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1035 Ridgeley St. 21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Smith

(a) RESIDENCE. No. 1035 Ridgeley St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 9 mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of R. Frank Smith

6 DATE OF BIRTH (month, day, and year) Dec 26/1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER Henry V Eyring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdelina Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant R Frank Smith
(Address) 1035 Ridgeley St.

15 Filed Jan 4 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 2 1922, to Jan 4 1923, that I last saw h[illegible] alive on Jan 3 1923, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Walter Storm, M. D.

1/4, 1923 (Address) 3405 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	Jany 6 1923

20 UNDERTAKER Joe Styer ADDRESS 1600 W North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70837

CERTIFICATE OF DEATH.

D70837

REGISTERED NO. 1924-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4002 Belle Ave ST.: (15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth H. Brandt

(a) RESIDENCE. No. 4002 Belle Ave ST., Forest Park WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. life. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 15. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Julius H Brandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prussia

12 MAIDEN NAME OF MOTHER Mary Gebb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Walter Hoffman (Address) 4002 Belle Ave Forest Park

15 Filed 5-1923 Robert F. Carrigan, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from October 15, 1922, to Jany 4, 1923, that I last saw h 21 alive on " 3 " 1923, and that death occurred, on the date stated above, at 12.40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
(Second attack)
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cirrhosis of liver & malignant tumor of stomach
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Geo. A. Hartman, M. D.

(Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cem.	Jan. 6 1923

20 UNDERTAKER Josiah Syfer

ADDRESS 1600 W. North Ave

D70838

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70838

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1532 Park Ave. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma C. Ruth

(Residence in Baltimore: No. 1532 Park Ave. St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. October 2nd (Month) (Day) 1868 (Year)

7-AGE. 53 yrs. 3 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. James Frederick Collins

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Naomi N. Hoffman

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George M. Collins

(Address) 3159 Cedar Ave.

15-

Filed ..... 192.....

1923 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. January 3rd (Month) (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroners (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. T. Hennessy M. D. (Coroner.)

Jan. 5th 192 3 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. Jan 5th 1923

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N. Bulls St

HEALTH DEPARTMENT--CITY OF BALTIMORE

D70839

CERTIFICATE OF DEATH

D70839

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1502 E. Fort- St. 24 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Julia Maddux.

(Residence in Baltimore: No. 1502 E Fort-

St.: 47 yrs. 10 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single.

6 DATE OF BIRTH: February 13, 1875 (Month) (Day) (Year)

7 AGE: 47 yrs. 10 mos. 21 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Hammerer.
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9 BIRTHPLACE (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Thomas Maddux

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Carroll

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Carpenter

(Address) 1502 E Fort ave.

15 Robert P. Harrison,

Filed ....., 191.....

Burial Permit Clerk

REGISTRAR

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January 4, 1912 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1911, to Jan 4 1912.

that I saw h alive on Jan. 3, 1912.

and that death occurred, on the date stated above, at 4 30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Influenzal

(Duration) ... yrs. 1 mos. ... ds

Contributory (SECONDARY) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed), Thos. F. Stevens M. D.

1-5, 1912 (Address) 2878 Hayward Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Jan 6, 1912

20 UNDERTAKER: Margaret A. Flynn

ADDRESS: 1722 Light St

If very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 38 ot Forrest Park Ave ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Woolford.

(a) RESIDENCE (Usual place of abode) No. 38 ot Forrest Park Ave., WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed or divorced HUSBAND of (or WIFE of) Isabella Woolford.

6 DATE OF BIRTH (month, day, and year) June 7th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Coal

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Maryland.

PARENTS

10 NAME OF FATHER Thomas Woolford.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Maryland.

12 MAIDEN NAME OF MOTHER Nancy Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland.

14 Informant Isabella Woolford. (Address) 38 ot Forrest Park Ave.

15 Filed Jan 5 - 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 3rd 1923

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Jan 3, 1923, that I last saw h[illegible] alive on Jan 3, 1923, and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

Arteris Sclerosis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Myocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

Jan 3 1923 (Address) 2604 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	1/6/23 19
20 UNDERTAKER	ADDRESS
H E Stinger	1st & Broadway

D.70841 HEALTH DEPARTMENT—CITY OF BALTIMORE

Riley
1609 N Broadway

CERTIFICATE OF DEATH.

3 D.70841
REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. City Jail ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Fitzsimmons

(Residence in Baltimore: No. 828 Light Street St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6-DATE OF BIRTH, Last Count, (Month) (Day) 1 (Year)

7-AGE, ~~About 40~~ 32 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cooper
(b) General nature of industry, business, or establishment in which employed (or employer): Wesley Carey

9-BIRTHPLACE, (State or Country): Balto Maryland

PARENTS.

10-NAME OF FATHER: Christopher E. Fitzsimmons
11-BIRTHPLACE OF FATHER (State or Country): Balto Maryland
12-MAIDEN NAME OF MOTHER: Mary Murphy
13-BIRTHPLACE OF MOTHER (State or Country): Balto Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward R. Fitzsimmons
(Address) ~~1609~~ 828 Light Street

15- 1023 Robert P. Harrison, 191 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) ..... (Day) 1913 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

..... (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. S. Riley M. D.
(Coroner.)
Jan 5 1913 (Address) 1609 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	1/7, 1913
20-UNDERTAKER W. M. Cook	ADDRESS 502 E. Fourth

(1) Fill out all items. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

160515
D70842

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 D70842

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Dieter.

(a) RESIDENCE NO. Graceland Park, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Maggie Dieter (wife).

6 DATE OF BIRTH (month, day, and year) April 22, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrical Engineer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Dieter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Md.

14 Informant JOHNS HOPKINS HOSPITAL Records (Address)

15 Filed 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1922, to Jan 5, 1923, that I last saw him alive on Jan 5, 1923, and that death occurred, on the date stated above, at 12.5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) of symptoms yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. ReBugg, M. D.

, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel

DATE OF BURIAL: 1/8 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Watts

Spec. 1-10-21 M&T 1500 Blks.

(Coby)

D70843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70843

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 China ST., 7th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Coby

(a) RESIDENCE NO. 806 China ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Sarah Coby

6 DATE OF BIRTH (month, day, and year) Feb. 2 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	11	one	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore 074

(b) General nature of industry, business, or establishment in which employed (or employer) Steamship Commercial Contracting

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co. Md
(State or country)

PARENTS

10 NAME OF FATHER John Coby

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. Md
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Guest

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co. Md
(State or country)

14 Informant Sarah Coby
(Address) 806 China St

15 Filed 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28th, 1922, to Jan 3rd, 1923, that I last saw him alive on Jan 3rd, 1923, and that death occurred, on the date stated above, at 7.44 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gen'l Physical Signs

(Signed) D. H. Chance M. D.

1/6, 1923 (Address) 140 N. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Jan 7 1923

20 UNDERTAKER John H. Toadvine — ADDRESS 143 Hillen St

Spec.—1-10-21—M&T—1500 Bks.

Irvin Ebaugh Park + N. Ave.

D70844

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

D70844

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 247 London Ave ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Lucinda Hitting

(a) RESIDENCE NO. 247 London Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. Hitting

6 DATE OF BIRTH (month, day, and year): Dec 18 1863

7 AGE: Years 59 Months 8 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Caleb Fuller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Margaret Cobler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): John H Hitting 247 London Ave

15 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1922, to Jan 4, 1923, that I last saw her alive on Jan 4, 1923, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Irvin Ebaugh, M. D.

, 19 (Address) 700 N. N Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine — DATE OF BURIAL: Jan 6 1923

20 UNDERTAKER: H. M. Cook — ADDRESS: 901 E. N. Ave

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

(Lueras)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70845 D70845

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Lueras (Louisa Ludowicka Lueras)

(a) RESIDENCE NO. 967 N. Chester St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if of foreign birth? 67 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Joseph Lueras

6 DATE OF BIRTH (month, day, and year) July 8 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant W. M. Frederick J. Lueras
(Address) 967 N. Chester St.

Filed 1923 Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1922, to Jan 5, 1923,
that I last saw h[illegible]ive on Jan 4, 1923,
and that death occurred, on the date stated above, at 1.05 p. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Insufficiency

(duration) yrs. mos wks ds.

CONTRIBUTORY (Secondary) Secondary Pneumonia

(duration) Hospital Acquired Pneumonia 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) S. W. Kouns, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan 8 1923
20 UNDERTAKER Henry Hoeck & Son	ADDRESS 1301 E Eager St

D70846 HEALTH DEPARTMENT—CITY OF BALTIMORE D70846

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C. 179

City of BALTIMORE: (No. 4006 Belvieu Ave St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aggie M. Wilson

(Residence in Baltimore: No. 4006 Belvieu Ave St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced. (Write the word) Married

6-DATE OF BIRTH. (Month) Sept. (Day) 17 (Year) 57

7-AGE, 50 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Lancaster, Pa.

PARENTS.

10-NAME OF FATHER, C. H. Mayer

11-BIRTHPLACE OF FATHER, (State or Country) Pa.

12-MAIDEN NAME OF MOTHER, Leah Kaufman

13-BIRTHPLACE OF MOTHER, (State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Wilson

(Address) 4003 Belvieu Ave

15- Robert P. Harrison,

Filed 1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) Jan. (Day) 3, (Year) 1923

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bl. degree burns.

(Duration) yrs. mos. 12 ds.

(Signed) J. T. Hemmeter M. D. (Coroner.)

Jan. 6 1923 (Address) 2 W. Edmondson Av.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. Drummond Lot 1/6 1923

20-UNDERTAKER. ADDRESS H. E. Hughes 424 N. Edward

D70847 HEALTH DEPARTMENT—CITY OF BALTIMORE D70847

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hosp St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... William H. Boyd

(Residence in Baltimore: No. 811 Bradley St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.)

6-DATE OF BIRTH, May (Month) 13 (Day) 1921 (Year)

7-AGE. 1 yrs. 8 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles Boyd

11-BIRTHPLACE OF FATHER, (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER, —— Burnett

13-BIRTHPLACE OF MOTHER, (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Boyd

(Address) 811 Bradley St

15- Filed 1923 192 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 4 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pertussis

(Duration) .....yrs.....mos.....ds.

(Signed) J. H. Dalton M. D.
(Coroner)

1-5 1923 (Address) 506 E Northern

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, mt auburn — DATE OF BURIAL, Jan 6th 1923

20-UNDERTAKER, Joseph A Farrell — ADDRESS 2219 Division St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70848 D70848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

34

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 526 Burgundy St. 27 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Jackson

(a) RESIDENCE. No. 526 Burgundy St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 11th 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER Willie Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Annie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Annie Williams
(Address) 513 Burgundy St

15 Filed 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/31/1923

17 I HEREBY CERTIFY, That I attended deceased from 11/12/1922 to 1/31/1923 that I last saw h alive on 1/21/1923 and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Psoas abscess of Rt Hip

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lyon Bowley, M. D.

, 19 (Address) 1085 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 5 1923

20 UNDERTAKER R. E. Gross ADDRESS 1405 McCulloh

D70849 HEALTH DEPARTMENT—CITY OF BALTIMORE D70849

CERTIFICATE OF DEATH.

179 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hosp St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mary Jones

(Residence in Baltimore: No. 1218 N. Pallas St., 17 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Single

6-DATE OF BIRTH. Aug 12 1905
(Month) (Day) (Year)

7-AGE. 17 yrs. 4 mos. 17 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Jackson Jones

11-BIRTHPLACE OF FATHER, (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hosp

(Address)

15-

Filed ..... 192.....

1923

Robert P. Harrison,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 29 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

accidental - 3rd degree burn over 1/2 surface of body, cloth caught from coal stove Dec 17/22 (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) none

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Pall M. D.
(Coroner.)

1-6 1923 (Address) 308 E. North ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. Laurel DATE OF BURIAL. Jan 5 1923

20-UNDERTAKER. R. C. Gross ADDRESS 1405 McElderry

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70850 HEALTH DEPARTMENT—CITY OF BALTIMORE D70850

CERTIFICATE OF DEATH. 1 X 32

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thad. Barnes.

(a) RESIDENCE. NO. Benedict, Md. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 9 ds. How long in U. S., if of foreign birth? yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE: Years 43 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Harriett Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hospital Records

15 Filed 1923, 19

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1922 to Jan. 5, 1923

that I last saw him alive on Jan. 5, 1923

and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Potts disease

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Lumbar Puncture

(Signed) [illegible] Jones, M. D.

1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Benedict Charles Co. Md. | DATE OF BURIAL: 1/3/23 19

20 UNDERTAKER: Samuel J. Kemsley | ADDRESS 578 N. Eddie

(Martel Gormer)

D70851

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70851

CERTIFICATE OF DEATH. 188-003

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Josephs Hosp St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Martel Gormer

(Residence in Baltimore: No. 327 E. Biddle St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. March 28 1873
(Month) (Day) (Year)

7-AGE. 49 yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cook
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). France

PARENTS.

10-NAME OF FATHER. Marcel Gormer

11-BIRTHPLACE OF FATHER, (State or Country). France

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Gormer wife

(Address) 327 E. Biddle St

15- Robert P. Harrison, 192.....

1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 4 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Taxi Cab accident - Dec 24/22
Hypostatic Pneumonia - Fracture
Pubis - bruises head & Face

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ~~Hypostatic Pneumonia~~

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Patten M. D.
(Coroner.)

1-6 192.3 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Marys Hampton	Jan. 6 1923
20-UNDERTAKER.	ADDRESS
P. F. Conley	438 E. North Ave

Spec.—1-10-21—M&T—1500 Bks.

D70852

HEALTH DEPARTMENT—CITY OF BALTIMORE

10 D70852

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3726 Foster Ave ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin Hausner

(a) RESIDENCE NO. 3726 Foster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 18-1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	10	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Hausner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Lemmister

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Kate Lemmister

(Address) 3726 Foster Ave

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/5 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/30/22, 19..., to 1/5/23, 19...,

that I last saw h[illegible] alive on 1/4/23, 19...,

and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

1 Diptheria Laryngeal

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. McGarrell M. D.

(Address) 633-5-St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Jan 6 1923

20 UNDERTAKER John Sellers

ADDRESS 2008 Eden

FRONT is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70853

CERTIFICATE OF DEATH.

179 D70853

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 118 So. Fifth ST. N WARD)

Registered No. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Ruggeiro

(Residence in Baltimore: No. 118 So. Fifth ST (3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan 22, 1918
(Month) (Day) (Year)

7-AGE, 5 yrs. 1 mos. 11 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Carmino Ruggeiro

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Angela Trotta

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam Carra

(Address) 118 So. Fifth ST

15-

Filed ....., 191.....

Robert P. Harrison,

Registrar.

1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 18
(Month) 4, (Day) 1923. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Extensive burns on back & sides - was treated at Johns Hopkins Hospital for 5 days

(Duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) playing with matches & set self on fire

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B. Morton M. D.
(Coroner)

Jan 14 1923 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Sacred Heart Cem

DATE OF BURIAL, Jan 6, 1923

20-UNDERTAKER John Dellario

ADDRESS 208 Albemarle

Spec.—1-10-21—M&T—1500 Bks.

D70854

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70854

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Md Gen Hospital St., 9 WARD)

2-FULL NAME Baby Dorgath

(a) RESIDENCE NO. 2797 Catalina St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 27, 1922

7 AGE Years 0 Months 0 Days 8 If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Otto Dorgath

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Sens

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Otto Dorgath
(Address) 2797 Catalina

15 Filed . 19 Robert F. Harrison, Registrar
1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/5/23 19

17 I HEREBY CERTIFY, That I attended deceased from 1/1/23, 19.... to 1/5/23, 19....,
that I last saw h[illegible] alive on 1/5/23, 19....,
and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:
Congenital Cobluloa

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted —
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical & Sympt

(Signed) J. A. Townsend M. D.

. 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Jan 7 1923

20 UNDERTAKER Mrs Wm John H. Leupold's Son — ADDRESS 801 N Gay St

INSTRUCTIONS ON BACK OF certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D70855

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70855

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Belmar Ave St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Rein

(Residence in Baltimore: No. 1 Belmar Ave St.; 64 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Sept 16th, 1845 (Month) (Day) (Year)

7-AGE, 77 yrs. 3 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Ret'd

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... George Rein

(Address)..... 1 Belmar Ave

15- Robert P. Harrison,

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 4th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1922, to Jan 4 1923, that I saw him alive on Jan 3 1923, and that death occurred, on the date stated above, at 9 45 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)..... yrs..... mos. 14 ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(Duration)..... yrs..... mos. 4 ds.

(Signed) Albert Wehle M. D.

Jan 5, 1923 (Address) 702 Bellair Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Balto Co. DATE OF BURIAL, 1/6, 1923

20-UNDERTAKER Philip Henry ADDRESS 2016 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

D70856

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70856

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 w Lanvale ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia A Myers

(a) RESIDENCE NO. 1620 w Lanvale ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas W Myers

6 DATE OF BIRTH (month, day, and year): [illegible] 1847

7 AGE — Years: 75 Months: 5 Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of Industry, business, or establishment in which employed (or employer): 537

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Chas Timmons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary M Dolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Mary E. Myers.

(Address): 1620 w Lanvale St.

15 Filed 1923, 19 ROBERT P. HARRISON, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 5. 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 - 1923, to Jan 5 1923.

that I last saw her alive on Jan 4 1923.

and that death occurred, on the date stated above, at 10 10 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Coma.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) some yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine. —

(Signed) [illegible], M. D.

1923, (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Jan 8th 1923

20 UNDERTAKER: John Cowan & Son per J.F. Cowan

ADDRESS: 901 Hollins St.

Very important. See Instructions on back of certificates.

Bureau of Vital Statistics

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70857 CERTIFICATE OF DEATH. 101-001 D70857

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 17 Lohrs Lane (Ward) Balto Md 20

2-FULL NAME Nicholas Johnson

(a) RESIDENCE NO. 17 Lohrs Lane ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Watts

6 DATE OF BIRTH (month, day, and year): 1853

7 AGE: Years 70; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): City
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Green Spring Valley Balto Md

PARENTS
10 NAME OF FATHER: Nat Johnson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Nicholas Johnson Jr.
(Address): 17 Lohrs Lane

16-1923 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/3 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/31, 1922, to 1/3, 1923, that I last saw h~~i~~e alive on 1/3, 1923, and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows: double lobar pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? 17 Lohrs Lane

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) [illegible] M. D.

, 19 (Address) 332 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Star Cemetery — DATE OF BURIAL: Jan 7, 1923

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS: 1114 W. Saratoga

[illegible] Burial Permit Clerk.

IONS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70858

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70858

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 333 Dolphin ST., 11 WARD)

2-FULL NAME A. Edward Arnold

(a) RESIDENCE NO. 333 Dolphin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 11 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Jan. 9 1851

7 AGE — Years: 71 — Months: 11 — Days: 26 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Muth Bros.

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Richard H Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Maria A Borches

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mr Henry Arnold

(Address): 333 Dolphin St

15 Filed ....., 19.... Registrar: Robert P. Garrison,

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15th, 1922, to Jan. 4th, 1923, that I last saw him alive on Jan. 2nd 1923, and that death occurred, on the date stated above, at 12 15 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -----

Did an operation precede death? No Date of -----

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) George L. Brand, M. D.

, 19 (Address) 721 N. Eutaw St;

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 1-6 1923

20 UNDERTAKER: Mrs Chas A G. Rohde

ADDRESS: 400 Arlington Ave

Very important. See instructions on back of certificates.

Spec. 6-3-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70859 D70859

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST.: WARD) REGISTERED NO. 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Jenfer.

(a) RESIDENCE. NO. 1629 Brunt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): June (?), 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	7	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Webster Jenfer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Henrietta Tempid

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant, (Address): Hospital Records

15 Filed 1923, 19 ROBERT P. HARRISON, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1922, to Jan 5, 1923, that I last saw her alive on Jan 5, 1923, and (that death occurred, on the date stated above, at 3:45 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria. nasal, tonsillar pharyngeal.

(duration) — yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) — yrs. 1 mos. 9 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Cultures (+)

(Signed) BMacgowan, M. D.

1/6/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Lawn	Jan 6 1923

20 UNDERTAKER: Dan. Easton ADDRESS: 916 Penna. Ave

Spec.--1-10-21--M&T--1500 Bks.

D70860

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70860

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Krauth

(a) RESIDENCE No. 3021 Elliott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 28 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margarethe Krauth

6 DATE OF BIRTH (month, day, and year) Dec 7 1858

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
64	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Wampell 086

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frederick Krauth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margaret Krauth

(Address) 3021 Elliott St

15 Filed JAN 6 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5, 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 19 22, to Jan. 5, 19 23,

that I last saw h.. alive on Jan 5, 19 23,

and that death occurred, on the date stated above, at 7 30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Sept 28 19

Was there an autopsy? yes

What test confirmed diagnosis? Operation Autopsy

(Signed) Captain Pannetier M. D.

, 19 (Address) Church Home and Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel DATE OF BURIAL Jan 8 19 23

20 UNDERTAKER Louis Heemann ADDRESS 3266 Brood way

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70864

CERTIFICATE OF DEATH.

X 111-001 D70861

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home Inf. St. [illegible] Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Tull.

(a) RESIDENCE NO. Uniontown, Md ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sallie Tull

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 68 Years | Months | Days | If LESS than 1 day, ..hrs or ..min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: S. M. Tull

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: A. L. Tull

(Address): Easton Md

15 Filed Feb. 19 1923 T. P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 26th, 1922, to Jan 6th, 1923.

that I last saw him alive on Jan 6th, 1923,

and that death occurred, on the date stated above, at 6.45 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) 30 yrs. ? mos ds.

CONTRIBUTORY (Secondary) Renal Tuberculosis

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Dec 30th 1922

Did an operation precede death? Yes Date of Jan 1st 1923

Was there an autopsy? No What test confirmed diagnosis? Physical and Operative Findings

(Signed) Cayetano Tamburro M. D.

, 19 (Address) Edenwald Hospital Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Md — DATE OF BURIAL: Jan 6 1923

20 UNDERTAKER: H C Troger — ADDRESS: 214 Baltimore

1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70862 D70862

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2817 W. Lanvale St. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Birmingham

(a) RESIDENCE. No. 2817 W. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 1. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary J. Birmingham

6 DATE OF BIRTH (month, day, and year) June 16 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	6.	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegrapher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hartford Conn

PARENTS

10 NAME OF FATHER Thomas F. Birmingham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Daly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Mary J. Birmingham
(Address) 2817 W. Lanvale St.

15 Filed 1923 19 ROBT. F. HARRISON, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1923, to Jan. 5, 1923, that I last saw him alive on Jan. 5, 1923, and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia - (Both Lungs) Type 4

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. R. Johnson, M. D.

1/5. 1923 (Address) 3926 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harford Conn — DATE OF BURIAL Jan 7 1923

20 UNDERTAKER Jacob Tyler — ADDRESS 16 W. North Ave.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D70863

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70863

CERTIFICATE OF DEATH

X 1-001

REGISTERED NO.....

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Greene ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm M. Letterman

(a) RESIDENCE. No. House of Correction Prince Md ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Letterman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Dr. Stewart Laurel. Md

15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/28 19 22

17 I HEREBY CERTIFY, That I attended deceased from 12/13, 19 22, to 12/28, 19 22

that I last saw h[illegible] alive on 12/28, 19 22

and that death occurred, on the date stated above, at 5[illegible] A. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 42 ds.

CONTRIBUTORY (Secondary) Hemorrhage (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? yes autopsy

What test confirmed diagnosis?

(Signed) Jno Riordan M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
JAN 6 - 1923
Commissioner H[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70864

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70864

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.; 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Bosley

(a) RESIDENCE. No. Upperco Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2, ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 3-23

7 AGE: Years | Months | Days: 27 hrs. | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Walter A Bosley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Emma Bosley Upperco Md

15 Filed 19 Robert P. Harrison Registrar

1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923, to Jan 4, 1923, that I last saw her alive on Jan 4, 1923, and that death occurred, on the date stated above, at 10 15 P m.

The CAUSE OF DEATH* was as follows:

Prematurity (Premies)

(duration) yrs. mos. 1. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical finding

(Signed) Anthony V Bucheri, M. D.

1/5, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JAN 6 1923

Commissioner Health

D70865 HEALTH DEPARTMENT—CITY OF BALTIMORE D70865

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 42 E. York St. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Kelly.

(Residence in Baltimore: No. 42 E. York St. St.; yrs. 70 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. Do not know. 1..... (Month) (Day) (Year)

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Report.

(Address).....

15- Robert F. Barrison,

1923 192 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, December 2kth. 1922. 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Eisenhardt M. D. (Coroner)

Jan, 4, 192 3. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

JOHNS HOPKINS HOSPITAL ....., 19....

20-UNDERTAKER. ADDRESS.

JAN 6 - 1923

MORGUE.

Spec.—8-24-14—M. & T.—2000 Bks.

70866 ✓ 70866

HEALTH DEPARTMENT—CITY OF BALTIMORE

70866
D70866

CERTIFICATE OF DEATH.

101-001

D70866

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2627 Hilton ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Louise McFee Williams

(Residence in Baltimore: No. 2627 Hilton St.; 44 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH, Dec 31, 1878 (Month) (Day) (Year)

7-AGE, 44 yrs. mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at Home 037

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, James H. McFee

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER Virginia R. Bowdle

13-BIRTHPLACE OF MOTHER (State or Country), Oxford, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H E Williams

(Address) 2627 Hilton St

15- Filed JAN 7 - 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 6, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 3 1923, to Jan 6 1923, that I saw her alive on Jan 5 1923, and that death occurred, on the date stated above, at 4:50 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm. L. Todd M. D.

Jan 6, 1923 (Address) 735 N. Bulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Jan 9, 1923

20-UNDERTAKER Ralph B Cook ADDRESS 1003 N. Ballo

Spec.—1-10-21—M&T—1500 Bks.

70867 70867 D70867

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D70867

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. WARD)

2-FULL NAME Elizabeth Cooke

(a) RESIDENCE NO. 1210 James ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas A. Coop

6 DATE OF BIRTH (month, day, and year) Dec. 20" 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Theodore T. Raeke

11 BIRTHPLACE OF FATHER (city or town) Berlin (State or country) Germany

12 MAIDEN NAME OF MOTHER Francis Kroovndiger

13 BIRTHPLACE OF MOTHER (city or town) Frankfort (State or country) Germany

14 Informant Thomas A. Coop (Address) 1210 James St.

15 Filed JAN 7 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5" 19 23

17 I HEREBY CERTIFY, That I attended deceased from January 1 19 23 to January 5 19 23, that I last saw h alive on January 5 19 23, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cellulitis (Hand) (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Jan 3-1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James Hurst Waltrous M. D.

1/5 1923 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 9 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-10-21—M&T—1500 Bks.

159186 D70868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Isaac E. Hess

(a) RESIDENCE NO. Esplande Apts. City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~: Widowed

6 DATE OF BIRTH (month, day, and year): Feb. 9 1859

7 AGE: Years 63 Months 10 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Manfacturer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

045

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Emanuel Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rebecca Rosenstock

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: JOHNS HOPKINS HOSPITAL. Records. (Address)

15 JAN 7 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1922 to Jan 6, 1923, that I last saw him alive on Jan. 6, 1923, and that death occurred, on the date stated above, at 2.55 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cortalx

(duration) 3 yrs mos ds.

CONTRIBUTORY (Secondary)* Cachexia (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene E. Thay M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Adat Shalom — DATE OF BURIAL: Jan 8 1923

20 UNDERTAKER: David Sondheim — ADDRESS: 118 N. Howard St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70869

CERTIFICATE OF DEATH. 74-001 D70869

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Boone ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane F. Elliott

(a) RESIDENCE NO. 2005 Boone ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1868

7 AGE — Years: 55 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Jos Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Kehoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs John T. Doyle

(Address) 2005 Boone st.

15 JAN 7 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1923, to Jan. 4, 1923, that I last saw her alive on Jan. 4, 1923, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Penazzo, M. D.

1.6.23. (Address) Sea Hills.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincents Cem.

DATE OF BURIAL: 1/8th 1923

20 UNDERTAKER: Chas F. Evans & Son

ADDRESS: 1810 Mt Royal ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70870 — CERTIFICATE OF DEATH. 74-001 D70870

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 Hanover St., 23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Ehrmandt

(a) RESIDENCE NO. 1021 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Ehrmandt

6 DATE OF BIRTH (month, day, and year) Dec 28th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	70	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 011

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret A Ehrmandt (Address) 1021 Hanover St

15 JAN 7-1923

16 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1923, to Jan 6, 1923, that I last saw h[illegible] alive on Jan 6, 1923, and that death occurred, on the date stated above, at 12 4 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chronic Nephritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Jan 7, 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Jan 9th 1923

20 UNDERTAKER E Schlossman & Son — ADDRESS 1034 Lemmon St

Spec.—8-24-14—M. & T.—2000 Bks.

D70871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D70871

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO. C.....

CITY OF BALTIMORE: (No..... ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Regina Kerber

(Residence in Baltimore: No. 1318 W. Northern ave St.: 41 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 1 (Day) 1869 (Year)

7-AGE, 53 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Asidore Fremkling

11-BIRTHPLACE OF FATHER (State or Country), Austria

12-MAIDEN NAME OF MOTHER Bailey

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E. Baltd St.

15- FILED JAN 7-1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 6 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 22 1922 to Jan. 6 1923 that I saw her alive on Jan. 6 1923, and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (terminal)

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Hypertrophic Arthritis Senility

(Duration) yrs. 3 mos. ds.

(Signed) Moses Zellman M. D.

Jan. 6, 1923 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Freedom DATE OF BURIAL, Jan. 7, 1923

20-UNDERTAKER Jack Lewis ADDRESS 1439 E. Balto

D70872

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70872

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Franklin Square Hospital 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Wallace Lane

(Residence in Baltimore: No. 1415 Longwood St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Dec 7 (Month) (Day) 88 (Year)

7-AGE. 41 yrs. 10 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Solicitor
(b) General nature of industry, business, or establishment in which employed (or employer): Maine Beans Boy

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. James Elvin Lane

11-BIRTHPLACE OF FATHER. (State or Country) Balto Co Md.

12-MAIDEN NAME OF MOTHER. Katherine E Buckey

13-BIRTHPLACE OF MOTHER. (State or Country) Carroll Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Bessie V Lane

(Address) 1415 Longwood St

15- JAN 7 - 1923 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry) find that said deceased came to Dec death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound through brain Suicide

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Jesse M Newton M. D.
(Coroner.)

Jan 6 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

1415 Longwood St

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery DATE OF BURIAL. Jan 8th 1923

20-UNDERTAKER. Leitham & Pope ADDRESS 1723 E Lafayette Ave

Spec.—1-10-21 M&T 1500 Bks.

D70873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70873

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 60 E Light ST. 23 WARD)

2-FULL NAME Minnie Louise Slaughter

(a) RESIDENCE NO. 60 E Light ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER William Edward Slaughter

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Emma Knauer

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant [illegible]
(Address) [illegible]

15 JAN 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1922, to Jan 6, 1923, that I last saw h[illegible] alive on Jan 6, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dila-
tation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cem

DATE OF BURIAL 1/8 1923

20 UNDERTAKER J. F. McCully

ADDRESS 1301 E. Fay

Spec.—1-10-21—M&T—1500 Bks.

D70874

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70874

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH South Balto Gen Hosp.

CITY OF BALTIMORE: (No. 1211 Light ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Brashears

(a) RESIDENCE NO. 131 E. Hart Ave: ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Brashears

6 DATE OF BIRTH (month, day, and year) March 14-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Laurel (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Brashears

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mr. Brashears (Son)

(Address) 131 E Hart

15 Filed JAN 7 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 5 1923

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1923, to January 5, 1923.

that I last saw him alive on January 5, 1923,

and that death occurred, on the date stated above, at 3 15 9. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted — if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John A McCarron, M. D.

, 19 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL 1/8 1923

20 UNDERTAKER E. F. McCully

ADDRESS 130 E. Hart

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70875

CERTIFICATE OF DEATH.

90 D70875

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1350 N. Washington ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Saupel.

(a) RESIDENCE. No. 1350 N. Washington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen Saupel

6 DATE OF BIRTH (month, day, and year) Dec. 18-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
60	60	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Pemchmidt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Saupel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant J. Paul Brown
(Address) 2125 Maryland Ave

15 JAN 7-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5- 1923

17 I HEREBY CERTIFY, That I attended deceased from April 15- 1919, to Jan. 5- 1923.

that I last saw h[illegible] alive on Jan. 5- 1923

and that death occurred, on the date stated above, at 10:25 P. m.

The CAUSE OF DEATH* was as follows: mitral regurgitation - Cardiac dilatation

about 10 yrs. mos. ds.
(duration)

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. Paul Brown, M. D.

19 (Address) 2125 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore City	1/8 1923

20 UNDERTAKER ADDRESS 1403

Henry Lutz Bro

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70876 D70876

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH 1721 N. Port st

CITY OF BALTIMORE: (No. 1721 N Port st ST., 8 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa Schwarzkopf

(a) RESIDENCE NO. 1721 N Port st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5. If married, widowed, or divorced HUSBAND of (or) WIFE of August Beck

6 DATE OF BIRTH (month, day, and year) March 15 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house work

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER William Stumpf

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Joe Schwarzkopf
(Address) 3722 Old Frederick Rd

15 Filed JAN 7 - 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1922 to Jan 6, 1923

that I last saw h[illegible] alive on Jan 4, 1923

And that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J. T. Fulton Reynolds, M. D.

1/8, 1923 (Address) 100 W Hatt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 8 1923

20 UNDERTAKER G. W. Dill — ADDRESS 319 Fremont Ave.

0137

HON is very important. See instructions on back of certificates.

(See Letter attached) ✓

D70877

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 D70877

1-PLACE OF DEATH Johns Hopkins Hosp. REGISTERED NO. C.....

CITY OF BALTIMORE (No. ~~3241 O'Donell~~ ST.: No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Karwacki

(Residence in Baltimore: No. 3241 O'Donell St St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) 3 (Day), ~~1916~~ 1917 (Year)

7-AGE, 5 yrs. 6 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

PARENTS.

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, John Karwacki

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Jena Josicinska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Karwacki

(Address) 3241 O'Donell St.

15- JAN 7 - 1923 ROBERT R. KRAUTER,

Filed....., 191..... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 5, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull - Auto
Shock

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Auto-truck accident

(Duration)....yrs....mos....ds.

(Signed) J. H. Haller M. D. (Coroner.)

1-6 1923 (Address) 508 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, Jan 8, 1923

20-UNDERTAKER Stephen J. Kalkowski ADDRESS 1005 Hanover St

508 NORTH AVENUE, EAST
BALTIMORE, MARYLAND

C. Hampson Jones
Health Officer

Dear Sir:- On death certificate of Louis Karacki died Jany 5/23, there seems to be a mistake in year of death he died 1917 instead of 1916. Kindly correct same & oblige-

J. S. H. Porter Secretary
508 E. North Ave

Jany 17/23

Spec.—1-10-21—M&T—1500 Blks.

D70878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D70878

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 S Dallas ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Felix Ratinski

(a) RESIDENCE NO. 521 S Dallas ST. 5 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 5-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				/

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Raymond Ratinski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Kozak

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Remond Ratinski
(Address) 521 S Dallas St

15 Filed JAN 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1923, to Jan 5, 1923, that I last saw h— alive on Jan 5, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bilat

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur Myers M. D.

Jan 6/23 (Address) 841 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Jan 6 1923
20 UNDERTAKER	ADDRESS
Stephen J Kalkowski	1000 N Kenwood Ave

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70879

CERTIFICATE OF DEATH.

100-001

D70879

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2831 Boarman ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip DeBlasi

(Residence in Baltimore: No. 2831 Boarman ave St.; 1 yrs., 4 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug 17, 1921 (Month) (Day) (Year)

7-AGE, 1 yrs. 4 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Michael DeBlasi

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Mary Bau

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael DeBlasi

(Address) 2831 Boarman Ave

15- Filed JAN 7 - 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 5, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1922 to Jan 5 1922, that I saw her alive on Jan 5 1922, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 2 ds.

(Signed) Wm. L. Kellam M. D.

Jan 6, 1923 (Address) 838 W. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross Cemetery A&C Co

DATE OF BURIAL, Jan 8, 1923.

20-UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70880

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

REGISTERED NO. D70880

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. #1-W-Wylie Ave ST., 27 WARD)

2-FULL NAME Travis Wilton Mullan

(a) RESIDENCE NO. #1-W-Wylie Ave ST., 28 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 33 yrs. 4 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Aug-23-1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Paper Business

(c) Name of employer: Whitaker Paper Co.

9 BIRTHPLACE (city or town) (State or country): Lynchburg Virginia

PARENTS

10 NAME OF FATHER: Robert Henry Mullan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Clarksburg W. Va.

12 MAIDEN NAME OF MOTHER: Elizabeth Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Surry Co. Va.

14 Informant (Address): Mr. Robt. H. Mullan Jr. (Son) Lynchburg Va.

15 Filed JAN 7 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1922, to January 6, 1923, that I last saw him alive on January 6, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Tonsilitis & Septicemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Mullan P Hall, M. D.

, 19 (Address) Wylie ave & Pendleton Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lynchburg - Va.

DATE OF BURIAL: Jan-7-1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE

Spec.—1-10-21—M&T—1500 Bks.

D70881 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D70881

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 N. Edem 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice V. McComas

(a) RESIDENCE NO. 1200 N. Edem ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (Husband of) (or) WIFE of: William A. McComas

6 DATE OF BIRTH (month, day, and year): May 31. 1862

7 AGE: Years 61; Months; Days; If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John L. Stanger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Gantown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Blanche V. Ruder (Address) 1200 N. Edem

15 JAN 7-1923, 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1923, to Jan 2, 1923, that I last saw h[illegible] alive on Jan 2, 1923, and that death occurred, on the date stated above, at 305 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis,

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Debility,

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [signature], M.D.

(Address) 1928 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. Stern Cem

DATE OF BURIAL: 1/8 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70882

CERTIFICATE OF DEATH.

101-001 D70882

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 W Chase ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Lyons—

(Residence in Baltimore: No. 225 W 11st Chase St.; 47 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Unknown

6-DATE OF BIRTH. unknown 1 (Month) (Day) (Year)

7-AGE. About 72 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Grocer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE. (State or Country) Cary Ireland

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Yakel

(Address) 1724 Linden Ave

15-

Filed JAN 7 1923 191.... ROBERT R. KRAUFER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan 6th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 3rd 1923, to Jan 6th 1923, that I saw h.m alive on Jan 5th 1923, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Advanced age

(Duration) 72 yrs. ..... mos. ..... ds.

(Signed) Chas J Keller M. D.

Jan 6, 1923 (Address) 222 W Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. New Cathedral

DATE OF BURIAL. 1/8, 1923.

20-UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70883

D70883

CERTIFICATE OF DEATH.

89

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1939 W Fayette ST. 20 WARD)

2-FULL NAME Susan M Custis

(a) RESIDENCE NO. 1939 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) March 3 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Amherst Va

PARENTS

10 NAME OF FATHER Thomas W Custis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Thomas W Custis

(Address) 1939 W. Fayette St

15 JAN 7-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 2, 1922, to Jany 5, 1923, that I last saw her alive on Jany 5, 1923, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 2 hrs ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M. A. O'Neill, M. D.

1/5, 1923 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harborton Virginia

DATE OF BURIAL 1/7 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Main St

(Instructions on back of certificate.)

D70884 HEALTH DEPARTMENT—CITY OF BALTIMORE D70884

CERTIFICATE OF DEATH. 197

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Nathan Harris

(Residence in Baltimore: No. 247 N. Dallas St. St.; 4 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. 1895
(Month) (Day) (Year)

7-AGE. 27 yrs.....mos.....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Georgia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. E. E. Johnson

(Address) 1420 Eastern Ave

15- JAN 7 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 30 22
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Gun Shot Wound - Homicide

(Duration) ....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs.....mos.....ds.

(Signed) Geo Edwin Bladel M. D.

(Coroner)

Jan 6 1923 (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cem.	1/7/22 19

20-UNDERTAKER,	ADDRESS
Geo. J. Puth	1735 Harford Ave

Spec.—1-10-21—M&T—1500 Blks.

D70885

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70885

CERTIFICATE OF DEATH.

111-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial St. Hospital WARD 27)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Dr. Elmer Cruzen (Cruzen) N.W. MARYLAND

(a) RESIDENCE NO. 504 Ropland Ave. ST., Ropland WARD Park, Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maud Carman

6 DATE OF BIRTH (month, day, and year) May 22, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	60	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cumberland (State or country) Md.

PARENTS

10 NAME OF FATHER John C. Cruzen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Union Memorial Hospital (Address) Balto. Md.

15 FILED JAN 7 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1923, to Jan. 5, 1923, that I last saw him alive on Jan 5, 1923, and that death occurred, on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows:

~~Cystitis~~

Duodenal ulcer

(duration) 5+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 4, 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P B Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL 1/8 1923

20 UNDERTAKER Henry W. Meas & Son — ADDRESS 805 N. Calvert St.

Fold. Use instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70886

D70886

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 135 (St.) [illegible] (Ward) 27

2-FULL NAME Sophie Wagner

(a) RESIDENCE NO. 135 N. Belvedere Ave (St.) (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or ~~Divorced~~, (write the word) Widow

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Frank Wagner

6 DATE OF BIRTH (month, day, and year) 1860.

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant [illegible]

(Address) [illegible]

15 JAN 7 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-5-1923

17 I HEREBY CERTIFY, That I attended deceased from 1-1-1922 to 1-5-1923

that I last saw h[illegible] alive on 1-3-1923

and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis, chronic nephritis, chronic bronchitis.

(duration) 1 yr. 2 mos. ds.

CONTRIBUTORY ~~(Secondary)~~ acute cardiac dilatation (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Dimarco, M. D.

1-6-1923 (Address) 1604 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lakeside Cem

DATE OF BURIAL 1/8 1923

20 UNDERTAKER [illegible]

ADDRESS 1318 Eighty

Important. See instructions on back of certificates. OCCUPA-

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70887 D70887

CERTIFICATE OF DEATH. 11-001

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 439 Patapsco Ave ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Rich

(Residence in Baltimore: No. 439 Patapsco Ave Brookly St.; 2 yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) S

6-DATE OF BIRTH, Nov 1, 1921
(Month) (Day) (Year)

7-AGE, 2 yrs. 2 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimd

PARENTS.

10-NAME OF FATHER, Joseph Rich

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Anna Blockmon

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Balt St

15- Filed JAN 7 - 1923, 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 7th, 1923
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4th 1923, to Jan. 7th 1923, that I saw her alive on Jan. 6th 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 3 ds.

(Signed) Harry Kleiber M. D.

1/7, 1923 (Address) 1624 Hanover St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Dehsen Rosedale DATE OF BURIAL, Jan 7, 1923

20-UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70888 D70888

CERTIFICATE OF DEATH.

X 133

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Schlining

(a) RESIDENCE. No. Catonsville Md ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. (ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Anna Schlining

6 DATE OF BIRTH (month, day, and year) Aug 19 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Liberty Printing Co Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Wm Schlining

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Krafs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Anna Schlining (Address) Prospect & Edmondson Av

15 Filed JAN 7 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-6- 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1922, to Jan 6, 1923, that I last saw him alive on Jan 6, 1923, and that death occurred, on the date stated above, at 3.35 P. m.

The CAUSE OF DEATH* was as follows:

Papillomata of Bladder

(duration) years

CONTRIBUTORY (Secondary) Bronchial Pneumonia (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Patient Examined

(Signed) J. B. Jones, M. D.

Jan 19 23 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ New Cathedral DATE OF BURIAL JAN 9 1923

20 UNDERTAKER Geo W Little ADDRESS 2700 EDMONDSON AVE

~~Corrections on back of certificates.~~

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70889

CERTIFICATE OF DEATH.

129 D70889

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 224 E. Lafayette Ave 12th WARD)

2-FULL NAME Laura Isabelle Shaw

(a) RESIDENCE. No. 224 E. Lafayette Ave 12th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Winchester, Virginia.

PARENTS

10 NAME OF FATHER John Shaw

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country) U.S.A.

12 MAIDEN NAME OF MOTHER Julia A. Kuntz

13 BIRTHPLACE OF MOTHER (city or town) Virginia (Winchester (State or country)

14 Informant Miss Elizabeth Wenby (niece
(Address) 224 E. Lafayette ave

15 JAN 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20th, 1922, to Jan. 5th, 1923.

that I last saw h[illegible] alive on Jan. 5th, 1923,

and that death occurred, on the date stated above, at 5.50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Ohme, M. D.

1/5, 1923 (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ London Park

DATE OF BURIAL JAN 8 1923

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

SUGGESTIONS ON BACK OF CERTIFICATES. — CAUSES OF DEATH AND NATURE OF OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70890

CERTIFICATE OF DEATH.

45 D70890

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Athol Ave Irvington ST., 20 WARD)

2-FULL NAME George Kerian

(a) RESIDENCE NO. Athol Ave Irvington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Elizabeth Kerian

6 DATE OF BIRTH (month, day, and year) July 8, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meat Business

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Kerian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Appel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Steinacker

(Address) 2914 Fenwick Ave

15 JAN 7 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 6 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 17, 1922, to Jany 5, 1923.

that I last saw him alive on January 5, 1923,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

a Heart

Carcinoma of Rectum 6

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry J Haberl M. D.

1/7, 1923 (Address) 2 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL Jan 9 1923

20 UNDERTAKER Wm Tickner & Sons — ADDRESS North Ave

See instructions on back of certificates.

Department of Occupa-

Spec.—1-10-21—M&T—1500 Bks.

D70891

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 D70891

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

2-FULL NAME Rosie Brown

(a) RESIDENCE NO. 757 Vine ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1860?

7 AGE — Years: 62 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.: M. N. Goldsmith

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: do

11 BIRTHPLACE OF FATHER (city or town) (State or country): do

12 MAIDEN NAME OF MOTHER: do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): do

14 Informant: Bay View Hospital
(Address) Balto, Md.

15 Filed JAN 7-1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1922 to Jan 4, 1923 that I last saw her alive on Jan 3, 1923 and that death occurred, on the date stated above, at 4 30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) M. N. Goldsmith M.D.

1/5, 19 23 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn City — DATE OF BURIAL: 1-8 1923

20 UNDERTAKER: George H. Holland — ADDRESS: 163 Lanvale St

Print in very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks. Samuel A Groomes

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70892 D70892

CERTIFICATE OF DEATH. 101-001

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1870 Bruck ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel A. Groomes

(Residence in Baltimore: No. 1870 Bruck St. Diff yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) M

6-DATE OF BIRTH, 1876 (Month) 1 (Day) (Year)

7-AGE, 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Other Groomes

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Henrietta Brayton

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Minnie Haines

(Address) 1870 Bruck

15- JAN 7 - 1923 Filed ....., 191.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 6th, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 15th 1922 to Jan 6th 1923, that I saw h[illegible] alive on Jan 6th 1923, and that death occurred, on the date stated above, [illegible] m.

The CAUSE OF DEATH* was as follows:

Robus Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

1160 [illegible] 191[illegible]. (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemty — DATE OF BURIAL, 1-9, 1923

20-UNDERTAKER George H. Holland — ADDRESS 1631 Druid

Spec.—1-10-21—M&T—1500 Bks.

D70893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D70893

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 N. Belnord ST. 6 WARD)

2-FULL NAME Augustin Giffrich

(a) RESIDENCE NO. 136 N. Belnord Ave ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Giffrich

6 DATE OF BIRTH (month, day, and year): Oct 5 1872

7 AGE: Years 50 Months 3 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Antone Giffrich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Huff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant (Address): Joseph Giffrich Govans Md

15 Filed JAN 7 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922 to Jan 6, 1923.

that I last saw h alive on Jan 6, 1923,

and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

Arter Sclerosis

(duration) yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. [illegible], M. D.

1923 (Address) 14 S Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: 1/8 1923

20 UNDERTAKER: J. J. Moran

ADDRESS 3000 E. Balto St.

Fold in very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

70894 D70894

HEALTH DEPARTMENT—CITY OF BALTIMORE

70894

133 D70894

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4508 St. Georges Ave. ST., 27 WARD)

2-FULL NAME Henry J. Blum

(a) RESIDENCE. No. 4508 St. Georges Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice M. Blum

6 DATE OF BIRTH (month, day, and year) Dec. 3, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			
	7			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) — 015

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Blum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Hennie Manning
(Address) 4508 St Georges Ave Balto

15 JAN 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1922, to Jan. 5, 1923, that I last saw him alive on Jan. 4, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cystitis
Urinary retention
Uraemia
3 weeks
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. D. Greenwood, M. D.

1/6/1923 (Address) 3949 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Jan 8 1923
20 UNDERTAKER	ADDRESS
C. A. Weedfield Jr	501 E 22 St

Spec.—1-10 21—M&T—1500 Blks.

70895
D70895

HEALTH DEPARTMENT—CITY OF BALTIMORE

70895

CERTIFICATE OF DEATH.

161-001 D70895

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1940 McHenry St. WARD 20)

2-FULL NAME Hugo Tillman

(a) RESIDENCE NO. 1940 McHenry St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 6. 22

7 AGE	Years	Months	Days	If LESS than 1 day 5 hrs or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Hugo Tillman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Bellinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Margaret Tillman
(Address) 1940 McHenry

15 Filed JAN 7—1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 6, 1923, to Jan 6, 1923.

that I last saw h— alive on Jan 6, 1923

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Premature Delivery
at 6th Month

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY —
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward W Jones M.D.

1-7 1923 (Address) 222 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters — DATE OF BURIAL Jan 8 1923

20 UNDERTAKER Mc-Mecks & Brady — ADDRESS 1737 N Gilmor St

Spec.—1-10 21—M&T—1500 Blks.—Penalty for making any false statement or concealing any material information required by this certificate is imprisonment for not more than one year or a fine of not more than $500.00 or both. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D70896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D70896

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(-PLACE OF DEATH

CITY OF BALTIMORE: No 306 N. Hoffman ST.: 17 WARD)

2-FULL NAME Charlotte Bowman

(a) RESIDENCE. No. 306 N. Hoffman ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
fem	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2nd 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~1 mo~~ 13		1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Clarence E Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lottie Greenwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) N. J. Greenwood 506 N. Hoffman

15 JAN 8 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 5th, 1923, to Jan 7th 1923, that I last saw h[illegible] alive on Jan 6th 1923, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

(a) Diphtheria
(Morbilli)
(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of 1-7 23

Was there an autopsy? No

What (est confirmed diagnosis? Above

(Signed) W. Grant Scott, M. D.

1/7, 1923 (Address) 204 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arbutus Evergreen — DATE OF BURIAL: 1/8 1923

20 UNDERTAKER: Samuel Hemsley — ADDRESS 578 N Biddle

(Instructions on back of certificates.)

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70897 100-501 ✓ D70897

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 Scott ST., 21 WARD)

2-FULL NAME George William Hall.

(a) RESIDENCE NO. 313 Scott ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year): July 9 1922

7 AGE — Years: — Months: 5 — Days: 28 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Henry F. Hall.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Vermont.

12 MAIDEN NAME OF MOTHER: Hagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Henry F. Hall
(Address) 313 Scott St.

15 Filed JAN 8 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1- 1923 to Jan 6 1923

that I last saw him alive on Jan 6 1923

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Acute bronchitis.

(duration) ..... yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Wm Engelmeyer M. D.

1923 (Address) 68 E Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 8th 1923
20 UNDERTAKER	ADDRESS
Geo Leimbach Co	647 W Pratt St

IT IS very important. See instructions on back of certificates. Exact statement of OCCUPA-

Filed 1939 No 12 1023

D70898

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70898

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 319 N Front St ST. 5 WARD)

REGISTERED No. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A Kling

(Residence in Baltimore: No. 319 N. Front St

Sex M yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	Married

6-DATE OF BIRTH, Aug 1, 1876
(Month) (Day) (Year)

7-AGE, 46 yrs. 2 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): 015

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. William Kling

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Catharine Kinch

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS ~~TRUE~~ TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola E Kling

(Address) 319 N Front St

15-

Filed JAN 8 - 1923, 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 6, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

Jan 7, 1923 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL,
Loudon Park	Jan 8, 1923

20-UNDERTAKER	ADDRESS
Wm Cook	502 E Fort Ave

Important. See instructions on back of certificate. [illegible] STATEMENT OF OCCUPATION is very

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not T. B.
Chronic Bronchitis

D70899

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

D70899

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE (No. 1207 Greenmount Ave St. 10 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Thomas G. Watkins

(Residence in Baltimore: No. 1207 Greenmount ave St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: January 21, 1882 (Month) (Day) (Year)

7 AGE: 40 yrs. 11 mos. 16 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Galvanizer
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9 BIRTHPLACE (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: William H Watkins

11 BIRTHPLACE OF FATHER (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Glenn

13 BIRTHPLACE OF MOTHER (State or country): Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) wm watkins

(Address) 1207 Greenmount Ave

15 JAN 8 - 1923 Filed ....., 191.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan 6, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1923, to Jan 6 1923 that I saw h-i alive on Jan 6, 1923 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis Nephritis

(Duration) ..... yrs. ..... mos. 4 ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Jan ....., 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: new cathedral cem

DATE OF BURIAL: January 8. 1923

20 UNDERTAKER: Mc Grimley & Carroll

ADDRESS: 4203 Ridgewood Ave

is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be the property classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70900 ✓ 44 D70900

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 10 E Chase St St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Randolph Bland

(a) RESIDENCE. No. Catonsville, md. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Maria Harden Bland

6 DATE OF BIRTH (month, day, and year) March 24, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work President & Treas.

(b) General nature of industry, business, or establishment in which employed (or employer) United States Fidelity & Guaranty Co. - Insurance

(c) Name of employer

9 BIRTHPLACE (city or town) St. Louis, (State or country) Missouri

PARENTS

10 NAME OF FATHER Richard Edward Bland

11 BIRTHPLACE OF FATHER (city or town) Westmoreland County (State or country) Virginia

12 MAIDEN NAME OF MOTHER Henrietta Williams

13 BIRTHPLACE OF MOTHER (city or town) Norfolk (State or country) Virginia

14 Informant (Address) R Howard Bland Catonsville, Md

15 Filed JAN 8 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 6, 1922, to Jan 6, 1923, that I last saw him alive on Jan 6, 1923, and that death occurred, on the date stated above, at 6.50 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Liver

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Cardiac failure & hypertension

(duration) 7 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None needed.

(Signed) Sydney R Miller, M. D.

, 19 (Address) 900 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Jan 8 1923

20 UNDERTAKER Henry A Jenkins & Sons Co ADDRESS Orchard & Calhoun Sts

Sections on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70901

CERTIFICATE OF DEATH.

90 D70901

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 402 Cathedral ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Rosalie McEvoy

(a) RESIDENCE. No. 402 Cathedral ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): married

5a If married, widowed, or divorced (or) WIFE of: P J McEvoy

6 DATE OF BIRTH (month, day, and year): Aug 4th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60		5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Philadelphia

PARENTS

10 NAME OF FATHER: Geo Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: P. McEvoy
(Address): 504 Cathedral St

15 JAN 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1923, to Jan. 7, 1923, that I last saw her alive on Jan. 7, 1923, and that death occurred, on the date stated above, at 2 30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. - mos. - ds.

CONTRIBUTORY (Secondary): Angina Pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History & Symptoms

(Signed) J. T. Owens, M. D.

1/8, 1923 (Address) 804 Cathedral St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	1-9 1923
20 UNDERTAKER: Henry W. Jenkins Sons Co	ADDRESS: Orchard & McCulloh

See instructions on back of certificates.

Spec.--6-9-19—H. P. Co.—1000 Bks.

D70902

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D70902

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 58 West Biddle St. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Mansfield Smith.

(a) RESIDENCE. No. 58 W. Biddle St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. 7 mos. 22 ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or WIFE of)~~ Fannie Abbott Smith

6 DATE OF BIRTH (month, day, and year) May 18 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Episcopal Clergyman Retired 1918

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Marshall Pike Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Law Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Fannie Abbott Smith

(Address) 58 W. Biddle St

15 JAN 8 - 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from July, 1922, to Jan 2nd, 1923

that I last saw him alive on Jan 2nd, 1923,

and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) sudden yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Examination

(Signed) J. A. Ireland, M. D.

Jan 8th, 1923 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	1-8-1923
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Sons Co	Orchard McCulloh

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70903 D70903

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 206 N Arlington Ave St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Lee

(Residence in Baltimore: No. 206 N arlington St.; yrs. 25 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-Single, Married, Widowed, or Divorced. (Write the word.) Mrd

6-DATE OF BIRTH. June (Month) 12 (Day) 1876 (Year)

7-AGE. 46 yrs. 5 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country): Maryland

PARENTS:

10-NAME OF FATHER. James Lee

11-BIRTHPLACE OF FATHER. (State or Country) Color'd

12-MAIDEN NAME OF MOTHER. Margaret Black

13-BIRTHPLACE OF MOTHER. (State or Country) Colored

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. Lee

(Address) 206 Arlington

15- Filed JAN 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan (Month) 4 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Virginia Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebro Spinal Meningitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James W. Fowler M. D. (Coroner.)

Jan 6 1923 (Address) 700 E Chase

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet DATE OF BURIAL. Jan 8 1923

20-UNDERTAKER. J. Wm. G. Lewis ADDRESS 313 Preston St

Form 6-9-19—H. P. Co.—1000 Bks.

D70904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D70904

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1111 Woodyear ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grafton Arthur

(a) RESIDENCE. NO. 1111 Woodyear ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 9 mos. 1 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 3, 1913

7 AGE — Years: 9 — Months: 9 — Days: 1 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy (Col'd)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles Arthur

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co. Md.

12 MAIDEN NAME OF MOTHER: Julia Etta Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Va.

14 Informant: Julia Etta Arthur (Address) 1111 Woodyear St

15 JAN 8 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 4 1923

17 I HEREBY CERTIFY, That I attended deceased from November 8, 1922, to January 4, 1923, that I last saw him alive on January 3, 1923, and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2+ mos. ds.

CONTRIBUTORY (Secondary): age 1

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Sputum.

(Signed) Helen F. Wright, M. D.

Jan 5, 1923 (Address) 1209 Presstman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn. — DATE OF BURIAL: Jan 8 1923

20 UNDERTAKER: James A. Deuro — ADDRESS: 301 Dunbar

D70905

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3rd

D70905

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daisy Moody

(Residence in Baltimore: No. 807 McKim St.; yrs. 6 mos. ds.) 6 years

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Unknown

6-DATE OF BIRTH, Unknown (Month) (Day) (Year)

May 16 1892

7-AGE, about 31 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Richard Ross

11-BIRTHPLACE OF FATHER, (State or Country), Va

12-MAIDEN NAME OF MOTHER, Patsy Ross

13-BIRTHPLACE OF MOTHER, (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Robert A. Elliott

(Address) 1725 Ashland ave

15- JAN 6 - 1923 Adolphus Hoge

Registrar. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, Jan 3rd 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)

Jan 7 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal. Balto. Md.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Stoney Creek Cem Co Va DATE OF BURIAL, Jan 8 1923

20-UNDERTAKER, Mrs Robert A. Elliott ADDRESS 1725 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

D70906

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D70906

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 Sterling ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Batson

(a) RESIDENCE NO. 830 Sterling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan. 6, 1922

7 AGE: Years — Months: 11 — Days: 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 6

(b) General nature of industry, business, or establishment in which employed (or employer): 6

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: John Batson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Pearl Bengon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mrs Pearl Batson 830 Sterling St.

15 JAN 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1923 to January 4, 1923.

that I last saw him alive on January 4, 1923.

and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr G W Kennard M. D.

1-5. 1923 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem.

DATE OF BURIAL: Jan. 8 1923

20 UNDERTAKER: Wm J. G. Locks

ADDRESS: 1312 Jefferson

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70907

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70907

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S. Arlington Ave. St. 18 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sullivan

(a) RESIDENCE. No. 105 S. Arlington Ave St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced (or) WIFE of Mary A Sullivan

6 DATE OF BIRTH (month, day, and year) March 7, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer) City Water Dept

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Timothy Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Corkery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary A Sullivan (Address) 105 S Arlington Ave

15 JAN 8 - 1923

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Jany 6, 1923, that I last saw h. alive on Jany 5, 1923, and that death occurred, on the date stated above, at 1.45A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) ✓ (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. A. Smith, M. D.

1/6, 1923 (Address) 108 N. Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Jan 9 19

20 UNDERTAKER John J Fields ADDRESS 1250 W Lombard 22

Spec.—1-10-21—M&T—1500 Bks.

D70908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70908

CERTIFICATE OF DEATH.

179

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 W. Lombard ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Goebel

(a) RESIDENCE NO. 801 W. Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 0 mos. 0 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Goebel

6 DATE OF BIRTH (month, day, and year) Sept 22, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	77	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of Industry, business, or establishment in which employed (or employer) Not

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Knapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary Schad

(Address) 3953 Fremont Ave

15 JAN 8 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1923, to Jan 5th, 1923.

that I last saw her alive on Jan 4, 1923.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos Grunbaum, M. D.

1923 (Address) 511 Cross

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Jan 8 1923

20 UNDERTAKER For Mrs. J. H. Teufel & Son

ADDRESS 801 W. Fayette

Instructions: Fill in all items. Use ditto marks only when necessary. Write plainly in ink. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70909

CERTIFICATE OF DEATH.

1-60 D70909

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 12 WARD)

2-FULL NAME Lydia E. Carter

(a) RESIDENCE NO. 507 W. 28th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maurice Carter

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44	—			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew J. Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Blakney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maurice Carter (Address) 507 W 28th St

15 JAN 8 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1922, to Jan 6, 1923, that I last saw h[illegible] alive on Jan 5, 1923, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical

(Signed) Chas. Wilbur Stewart, Indiana M. D.

(Address) Maryland General Hosp. 6, 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Providence Cem.	Jan 9 1923
20 UNDERTAKER	ADDRESS
John Burns Sons	Towson

Very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D70910

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 4 WARD)

2-FULL NAME Moses Sedg

(a) RESIDENCE NO. Stevensville, Md St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 22 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70.	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Moses Sedg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ann Wrightson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Record

(Address)

15 JAN 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1922, to Jan 7, 1923, that I last saw him alive on Jan 6, 1923, and that death occurred, on the date stated above, at 3.50 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) D. J. Wilson M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Stevensville Md.

DATE OF BURIAL: 1-8 1923

20 UNDERTAKER: E & B Hale

ADDRESS: 115 E West St

Carefully important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70911

CERTIFICATE OF DEATH.

74 89 D70911

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2624 E Hoffman ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie E Michelmann.

(a) RESIDENCE. NO. 2624 E Hoffman ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry H. M. Michelmann

6 DATE OF BIRTH (month, day, and year) Dec. 22 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ill Unk

12 MAIDEN NAME OF MOTHER Unk Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ill Unk

14 Informant Henry H. M. Michelmann

(Address) 2624 E Hoffman St.

15 Filed JAN 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 1922 to Jan 4 1923

that I last saw her alive on Jan 4 1923

and that death occurred, on the date stated above, at 5-20 P.M.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) yrs. 3 mos. 15 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Albert L. Hesser, M. D.

Jan 5 1923 (Address) 1211 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 1-8 1923

20 UNDERTAKER: Mrs Chas A G. Rohde — ADDRESS: 600 N Arlington Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70912

CERTIFICATE OF DEATH.

90 D70912

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1740 Hanover St. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael R. Gaither.

(a) RESIDENCE NO. 1740 Hanover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widow.

5a If married, widowed, or ~~divorced~~ HUSBAND of ~~WIFE~~ Dennis W. Gaither

6 DATE OF BIRTH (month, day, and year) April 17, 1843.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER David Mewshaw.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Susanna Watts.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md.

14 Informant John L. Seymour. (soninlaw)

(Address) 1740 Hanover St.

15 FILED JAN 8 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January, 5 1923.

17 I HEREBY CERTIFY, That I attended deceased from October 22, 1922 to January 5 1923.

that I last saw her alive on January 5th. 1923.

and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ------

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M. Reinhardt M. D.

1/6, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Melville Chapel, Elkridge DATE OF BURIAL Jan 8 1923

20 UNDERTAKER Mrs J. E. Evans ADDRESS 1428 E Charles St

6 Sons

IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70913

CERTIFICATE OF DEATH.

11-001 D70913

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 726 Ayax St. 10 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Walter Gant

(a) RESIDENCE. No. 726 Ayax St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of x

6 DATE OF BIRTH (month, day, and year) July 7th, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jas. Co. Balto Md.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank Gant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co Md

12 MAIDEN NAME OF MOTHER Sarah Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Sarah Gant

(Address) 726 Ayax St

15 JAN 8 - 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st. 1922. to Jan 5 1922. that I last saw him alive on Jan 5 1922, and that death occurred, on the date stated above, at 9.30 A.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Regular

(Signed) Jan 6 F. E. Link M. D.

(Address) 1313 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Jan. 8 1923
20 UNDERTAKER	ADDRESS
Mrs J. G. Locks	1302 Jefferson

Directions for filling out certificates on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70914

CERTIFICATE OF DEATH.

185 D70914

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Castle ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Bachmann

(a) RESIDENCE NO. 517 N. Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed or divorced ~~HUSBAND of~~ (or) WIFE of: late Theo. Bachmann

6 DATE OF BIRTH (month, day, and year): Aug 29 - 49

7 AGE: Years 73 Months 4 Days 8 If LESS than 1 day, hrs. or min.

8 ~~OCCUPATION~~ OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Tillie Buchmann

(Address) 517 N. Castle St.

15 JAN 8 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 27th, 1922, to Jan 6th, 1923,

that I last saw her alive on Jan 6th, 1923,

and that death occurred, on the date stated above, at 4:50 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia (Chron.)

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J. Russell, M. D.

, 19 (Address) 156 N. Milton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bulls Elm.

DATE OF BURIAL: 1/9 1923

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Aliceanna

THIS IS very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70915

CERTIFICATE OF DEATH.

129 D70915

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 S. First ST., 25 WARD)

2-FULL NAME Geo. H. Reimann

(a) RESIDENCE No. 29 S. First ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 7, 1888

7 AGE: Years 34 Months 3 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Brooklyn Md.

PARENTS

10 NAME OF FATHER: Geo H. Reimann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary J. Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Mrs Reimann 29 S. First St.

15 JAN 8 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1923

17 I HEREBY CERTIFY, That I attended deceased from ~~Jan 30 1921~~, ~~1922~~, to Jan 6, 1923.

that I last saw h[illegible] alive on Jan 6, 1923,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Duration made by Chas H Brook (2-17-22)

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brook M. D.

192 (Address) Brookfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Jan. 9 1923

20 UNDERTAKER: Margaret G. Flynn — ADDRESS 1422 Light St.

NOTE—Every important "See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D70916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70916

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Hanover ST.: 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie A. Matthews

(a) RESIDENCE. No. 922 Ridgely ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clifton A. Matthews

6 DATE OF BIRTH (month, day, and year) May 20 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Agnes Norman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Clifton A. Matthews (Address) 922 Ridgely St

15 Filed JAN 8 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 5, 1923, that I last saw h[illegible] alive on Jan 5, 1923 and that death occurred, on the date stated above, at 11-30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. E. K. Campbell M. D.

Dec 28 19 23 (Address) 1624 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL Jan 9 1923

20 UNDERTAKER Margaret J. Flynn ADDRESS 1422 Eiger St.

Fill in all blanks. Be sure to read directions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70917 CERTIFICATE OF DEATH. 161-001 D70917

1-PLACE OF DEATH Johns Hopkins Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 5 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Guest.

(a) RESIDENCE NO. 5. N. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 31-1922.

7 AGE	Years	Months	Days	If LESS than 1 day, 22 hrs. or min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — ppb

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Johns Hopkins Hospital.
(State or country)

PARENTS

10 NAME OF FATHER ? Hays

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) ?

12 MAIDEN NAME OF MOTHER Emma Guest.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant W W Gray
(Address) Johns Hopkins Hospital.

15 Filed JAN 8 - 1923 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1922, to Jan 1, 1923, that I last saw her alive on Jan 1, 1923, and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

Congenital

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W W Gray, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 1/4 1922

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health,

FROM BABY IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70918 D70918

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH Johns Hopkins Hospital.

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Breckenridge

(a) RESIDENCE NO. 332 W Preston ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan. 3/23

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs+ or 57 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work $00

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Balto, Md. (State or country)

PARENTS

10 NAME OF FATHER Alexander Breckenridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jennie Stith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Wm Gray

(Address) Johns Hopkins Hospital

15 JAN 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923. to Jan 3, 1923.

that I last saw her alive on Jan 3, 1923,

and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ✓

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Wm Gray, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Hospital

DATE OF BURIAL 1/7 1923

20 UNDERTAKER

ADDRESS

Commissioner of Health,

FOR IS very important. See instructions on back of certificates. PART Statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70919 D70919

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1311 Herkimer ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Slobodin

(a) RESIDENCE NO. 1311 Herkimer ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE 54 Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mary Slobodin

(Address) 1311 Herkimer Street

15 JAN 6 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Janv 6th 1923

17

I HEREBY CERTIFY, That I attended deceased from 6 January, 1923, to 6 January, 1923.

that I last saw him alive on 6 January, 1923,

and that death occurred, on the date stated above, at 8.P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) / yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph Hospelhorn, M. D.

, 19 (Address) East Coal & Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Janv. 9. 1923

20 UNDERTAKER: John Grebliauckas — ADDRESS: 425 S Paca St

F.D.

FROM a very important. See instructions on back of certificates.

Personally appeared before me this 12th day of January 1923, John Grebliauckas, and made affadavit that the age given on death certificate #D-70919 as 54 years is incorrect. Same should be 46 years. and 25 days.

John Grebliauckas

Subscribed to and sworn before me this 12th. day of Januuary , 1923.

Reed Gardner
Notary Public.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70920

CERTIFICATE OF DEATH.

3 D70920

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 Diller Ave. (Gardenville) ST. 27 WARD)

2-FULL NAME Lucy Sippel

(a) RESIDENCE NO. 20 Diller Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) November 23 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady 067

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Louis Sippel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Kuran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Barbara Bittle

(Address) 20 Diller Ave.

15 ROBERT R. KRAUTER JAN 8 — 1923 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from November, 1922, to Jan 6th, 1923, that I last saw her alive on Jan 5th, 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ~~7~~ ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J Russell M. D.

, 19 (Address) 1516 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Jan 9 1923

20 UNDERTAKER Henry Storck Son ADDRESS 1301 E Eager

FROM is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70921 HEALTH DEPARTMENT—CITY OF BALTIMORE D70921

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 N Exeter St., 5 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Kraeger

(a) RESIDENCE NO. 417 N. Exeter St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. — mos. — ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Bernard Kraeger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Annie Hamman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. Louis Kraeger

(Address) 417 N Exeter St

15 Filed JAN 7 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1922, to Jan 6, 1923,

that I last saw her alive on Jan 6, 1923,

and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Organic Dementia

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No. General symptoms & What test confirmed diagnosis? 3 Nerve specialists.

(Signed) Mary F. Voeglein, M. D.

1.7. 1923. (Address) 1028 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Jan. 10, 23

20 UNDERTAKER: Henry Hoerle & Son — ADDRESS: 1301 E Eager St

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70922

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 823 E. Chase ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Rooney Jr.

(a) RESIDENCE NO. 823 E Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 14 1887

7 AGE — Years: 35 Months: 6 Days: 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Professional. Bartender

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John. P. Rooney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Susan MacGregor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mr John T. Rooney

(Address) 823 E Chase St

15 Filed Jan 9 1923 Burial Permit Issued

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1922, to Jan 6, 1923, that I last saw him alive on Jan 4, 1923, and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Story, M. D.

Jan. 9, 1923 (Address) 677 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Jan. 9 1923

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager St

Jan 23

Sec. 18 of the Act requires that every physician, undertaker or person in charge of interment shall deliver to the person receiving the body of a deceased person a burial permit, stating the time and place of interment, before the body is buried, removed or cremated. See instructions on back of certificates.

MURPHY ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70923 — 90 — D70923

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Murphy

(a) RESIDENCE. No. 1638 Lemmon ave., St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Murphy

6 DATE OF BIRTH (month, day, and year) Feby 19 1866 Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework.

(c) Name of employer self.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Frazier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) University Hospital Records

15 Filed JAN 8 - 1923

JAN [illegible] ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/7 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/30, 1922, to 1/7, 1923,

that I last saw her alive on 1/7, 1923,

and that death occurred, on the date stated above, at 7:55 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis and Insufficiency.

~~Diffuse bilateral bronchopneumonia~~

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diffuse Bilateral bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. A. Calkins, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additionnl spnce.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Jan. 10 1923

20 UNDERTAKER: Henry Storck & Son — ADDRESS: 1301 E Eager St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70924 44 D70924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3849 Roland Ave. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Shelley

(a) RESIDENCE. No. 3849 Roland Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. How long in U. S., if of foreign birth? 54 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma Shelley

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of Industry, business, or establishment in which employed (or employer) 054

(c) Name of employer None

9 BIRTHPLACE (city or town)
(State or country) England

PARENTS

10 NAME OF FATHER John Shelley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Susan Benton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Harry Shelley
(Address) 3849 Roland Ave

JAN 8 - 1923 19 ROBERT P. LAMOTTE
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6 1923

17 I HEREBY CERTIFY, That I attended deceased from September 1, 1922, to January 6, 1923, that I last saw him alive on Jan 5, 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Malignant Cachexia

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Gastric Carcinoma

(duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of Oct. 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Symptoms (operation)

(Signed) Frank H. Mackie, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Jan. 8 192 3
20 UNDERTAKER	ADDRESS
Martin Bakys Co	1870 North

Spec.—1-10-21—M&T—1500 Bks.

✓ D 70925

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70925 — 58-001 — D70925

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 524 N. Ann ST., Ciemienski WARD)

2-FULL NAME Maria Kimins Ra

(a) RESIDENCE NO. 524 N. Ann ST., 2 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	00		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Maine

PARENTS

10 NAME OF FATHER Matthias

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Maine

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Maine

14 Informant Anne Kapanski (Address) 524 N. Ann St

15 Filed JAN 8 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6 1923

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1923, to January 1, 1923, that I last saw h alive on January 1, 1923, and that death occurred, on the date stated above, at 1 15 p. m.

The CAUSE OF DEATH* was as follows:

General debility

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [illegible], M. D.

1-6-, 1923 (Address) 722 S. Ann

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Jan 9 1923

20 UNDERTAKER John M Weber — ADDRESS 1803 Bank St

TION is very important. See instructions on back of certificates.

St Thomas Roland Ave. Annie E. DeLat

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70926

CERTIFICATE OF DEATH.

90 D70926

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2507 Druid Hill St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. DeLat

(Residence in Baltimore: No. 2507 Druid Hill St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, July 21, 1848 (Month) (Day) (Year)

7-AGE, 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At Home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis H. DeLat

(Address) 2507 Druid Hill

15- JAN 8 - 1923

16-ROBERT R. KRAMER

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 6, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and (Inquest or inquiry.) thereon and from the evidence obtained at said (Inquest) autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Angina Pectoris

3 Years

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John H. Morrison M. D. (Coroner)

Jan 7, 1923 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Jan 8, 1923

20-UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70927 — 23 D70927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital — REGISTERED NO. C.....

CITY OF BALTIMORE: (No..... ST.; 23 ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Uscher Cohen

(Residence in Baltimore: No. 912 S. Charles St — St.; 1 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. ..... March ....., 1867
(Month) (Day) (Year)

7-AGE. 56 yrs. — mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1439 Gilmor St

15- FILED JAN 8 - 1923, 191... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 8, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 23 191, to Jan 8, 23 191, that I saw him alive on January 8/23 191, and that death occurred, on the date stated above, at 3:20 a m.

The CAUSE OF DEATH* was as follows:

Acute Epidemic Encephalitis

..... (Duration)..... yrs..... mos. 11 ds.

CONTRIBUTORY..... (Secondary)

..... (Duration)..... yrs..... mos..... ds.

(Signed) Moses Gellman M. D.

Jan. 8/23 191... (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. 3 ds. In the State 1 yrs. 6 mos. ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence 912 S Charles St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run — DATE OF BURIAL, Jan 8, 1923

20-UNDERTAKER Jack Lewis — ADDRESS 1439 Gilmor St

D70928

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70928

CERTIFICATE OF DEATH.

4 167

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE. (No. 752 W Fayette St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Maudel

(Residence in Baltimore: No. 752 W Fayette St St.; yrs. ..... mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Dont Know 1878
(Month) (Day) (Year)

7-AGE. 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Nathan Maudel

11-BIRTHPLACE OF FATHER. (State or Country) Russia

12-MAIDEN NAME OF MOTHER. Sarah ~~Dont Know~~

13-BIRTHPLACE OF MOTHER. (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Cummyns

(Address) 3 W. Eutaw

JAN 8 - 1923

Filed ..... 192 ..... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan 2 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... Inquest, aut. find that said deceased came to ~~his~~ death ~~topsy or inquiry.~~ on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Asphyxiation

(Duration) a few hours

CONTRIBUTORY (Secondary) Probably Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Gonsuch M. D.
(Coroner.)

1 to 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. 7 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Phila Pa

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Phila Pa	Jan 8 1923

20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 Gilmor

D 70929

Spec.—1-10-21—M&T—1500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70929 — 100-001 — D70929

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 947 W Lexington ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Custy

(a) RESIDENCE NO. 947 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia Custy

6 DATE OF BIRTH (month, day, and year): March 17th 1846

7 AGE — Years: 77 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): House Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Denis Custy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Cronin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary Murphy

(Address): 947 W Lexington

15 Filed: JAN 8 – 1923 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1923 to Jan 6 1923

that I last saw him alive on Jan 6 1923

and that death occurred, on the date stated above, at 7.50 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Acute bronchitis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) M C Brannigan M. D.

1923 (Address) 682 Columbus Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 1-9 1923

20 UNDERTAKER: H. C Brannigan Son

ADDRESS 517 N. Schroeder St

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70950

CERTIFICATE OF DEATH.

90 D70930

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Eutaw Place St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth J. Byrd

(a) RESIDENCE. No. 1810 Eutaw Pl St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 10 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-26-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Colmore E. Byrd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Sheldon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Fletcher Lee Byrd

(Address) 1810 Eutaw Place

15 Filed JAN 8 1923 Registrar ROBERT R. CRAWFORD

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1922, to Jan 7, 1923, that I last saw her alive on Jan 6, 1923 and that death occurred, on the date stated above, at 4. A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

Broncho pneumonia

3 days

(Duration—yrs. mos. ds.)

CONTRIBUTORY (Secondary) Chronic Myocardial Insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Lockard, M. D.

Jan 8 1923 (Address) 42 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Jany 9 1923

20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fayette St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70931 D70931 101-001

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 884 Pierce ST., 18 WARD)

2-FULL NAME Emory Anderson

(a) RESIDENCE NO. 884 Pierce ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	negro	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Phillips
(Address) 884 Pierce St

JAN 8 - 1923
Filed ..... 1923 ROBERT R. CRAWLEY Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1922, to Jan 6, 1923, that I last saw h[illegible] alive on Jan 5, 1923 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Bilateral Lobar Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis? Urinary

(Signed) J. S. Mackie, M. D.

Jan 7 1923 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery — DATE OF BURIAL 1/8/23

20 UNDERTAKER Samuel H. Kemeley — ADDRESS 578 W. Baltimore

THIS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70932 HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D70932

CERTIFICATE OF DEATH

1-PLACE OF DEATH Robert Garrett Hosp for Children REGISTERED NO.

CITY OF BALTIMORE: (No. 27 N. Carey ST., V WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Fournaros

(a) RESIDENCE NO. 1708 Lancaster ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 22 1922

7 AGE: Years — Months: 7 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Fournaros

11 BIRTHPLACE OF FATHER (city or town) (State or country): ~~Baltimore~~ Greece

12 MAIDEN NAME OF MOTHER: Rosa Galeta

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece

14 Informant (Address): James Fournaros 1708 Lancaster st

15 JAN 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1922, to Jany 7, 1923.

that I last saw him alive on Jany 7, 1923.

and that death occurred, on the date stated above, at 6 30 8 m.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

+ Double Otitis Media

Purulent

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Cardio Respiratory failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical

(Signed) J. P. L. Pliff M. D.

1/7, 1923 (Address) 27 N Carey st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Jan 10 1923

20 UNDERTAKER: H. Sander & Sons — ADDRESS: 1707 Eutaw st.

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D70933

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Annie Durham

(a) RESIDENCE NO. 1134 E. North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: ~~White~~ Black

5 Single, Married, Widowed, or Divorced, (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 10 - 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
♀	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steno nat business

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Durham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Margaret Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Johns Hopkins Hospital

15 Filed: JAN 8 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 6 1923 to January 1923, that I last saw her alive on Jan 6 1923, and that death occurred, on the date stated above, at 10:20 17 m.

The CAUSE OF DEATH* was as follows:

Recurrent carcinoma of primary in breast- metastases in bones and lungs.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1920

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Fred A Allen M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL 1/9th 1923

20 UNDERTAKER: Chas P. Evans & Son — ADDRESS 1118 N. Eutaw & Royal Ave

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70934

CERTIFICATE OF DEATH.

23

D70934

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 N. Fulton ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Blessing

(Residence in Baltimore: No. 615 N Fulton ave St.; Lifetime yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 26, 1854 (Month) (Day) (Year)

7-AGE, 63 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Peter

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Laura Grace

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel G. Blessing

(Address) 615 N. Fulton Ave

15- JAN 8 - 1923 filed....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 6, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 18 1922, to Jan 6 1923, that I saw h-- alive on Jan. 4 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

.....

.....

..... (Duration) yrs. mos. 15 ds.

CONTRIBUTORY Exhaustion

(Secondary)

Pulmonary Oedema (Duration) yrs. mos. 1 ds.

(Signed) M. D.

1/6/, 1923 (Address) 834 Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery DATE OF BURIAL, 1/8, 1923

20-UNDERTAKER Chas. S. Coale & Son ADDRESS 11 West Royal ave

Spec.—1-10-21—M&T—1500 Bks.

D70935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D70935

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 Longwood ST., 15 WARD)

2-FULL NAME John Willeden Gormley

(a) RESIDENCE NO. 1720 Longwood ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L Gormley

6 DATE OF BIRTH (month, day, and year) Sept. 9. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER Mathew Gormley

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.S.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mary L Gormley

(Address) 1720 Longwood St

15 JAN 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 26th, 1922, to Jan 7, 1923,

that I last saw him alive on Jan 6th, 1923,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) 10 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cardiac Ischaemia

(duration) ... yrs. ... mos. 12 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Herbert E. Zepp, M. D.

Jan 8, 1923 (Address) 3048 N. Monte Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Jan: 9 1923

20 UNDERTAKER C. W. Dill — ADDRESS 3109 Fredk. Ave.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70936

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Agnes Hospital ST., 75 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis G. Mueller

(a) RESIDENCE NO. 113 McTavish Ave ST., WARD

(Usual place of abode) Violetville (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: Frieda Mueller

6 DATE OF BIRTH (month, day, and year): Dec 9. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
60	—	—	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer): /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frieda Mueller

(Address): 113 McTavish Ave

15 JAN 8 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 6 - 1923 to Jan 7 - 1923.

that I last saw him alive on Jan 7 1923

and that death occurred, on the date stated above, at 1.35 P.M.

The CAUSE OF DEATH* was as follows:

Acute Exacerbation Chronic Hepatitis

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mary Sullivan, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan: 9 1923

20 UNDERTAKER: Chas W. Dill — ADDRESS 3109 Fredk: Ave.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70937

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70937

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 16 WARD)

2-FULL NAME Charles E. Pearce

(a) RESIDENCE NO. Unknown Elkton Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	74	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records.
(Address)

15 1923 Robert P. Harrison, 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 19, 19 22, to Jan. 7, 19 23.

that I last saw him alive on January 7, 19 23.

and that death occurred, on the date stated above, at 7:15 P. M.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X-ray- Gen. Anal. Cy

(Signed) Clyde Mitchell, M. D.

1/8, 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton Md.

DATE OF BURIAL 1/8 1923

20 UNDERTAKER W. J. Tickner Sons North Penna St

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70938

D70938

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 E. Eager ST., 7 WARD)

2-FULL NAME. Marie Viktor

(a) RESIDENCE NO. 1706 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? 52 yrs. 6 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph F. Viktor

6 DATE OF BIRTH (month, day, and year) Sept 6th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Bohemia (State or country) Europe

PARENTS

10 NAME OF FATHER Joseph Kapialek

11 BIRTHPLACE OF FATHER (city or town) Bohemia (State or country) Europe

12 MAIDEN NAME OF MOTHER Anna Jarujek

13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country) Europe

14 Informant (Address) Joseph F. Viktor 1706 E. Eager St.

15 JAN 1923, 19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7 1923

17 I HEREBY CERTIFY, That I attended deceased from 12-26, 19 22 to 1-7, 19 23

that I last saw h alive on 1-6, 19 23

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation — Hypertension

Arterial Degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & P.M.

(Signed) F. F. Kunjeda, M. D.

, 19 (Address) 2000 Orleans St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 9 1923
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

THON is very important. See instructions on back of certificates.

D70939

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70939

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hosp St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Wm J Dempsey Jr

(Residence in Baltimore: No. 935 N. Duncan St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Dec (Month) 9 (Day) 1914 (Year)

7-AGE. 8 yrs. 0 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School Boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. Wm J. Dempsey

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER. Anna E. Scott

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J. Dempsey Sr

(Address) 935 N. Duncan

15- Robert P. Harrison, 192

1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 5 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Concussion Struck by
Automobile

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs.....mos.....ds.

(Signed) J. S. T. Dallin M. D. (Coroner)

1-6 1923 (Address) 508 E North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Baltimore

DATE OF BURIAL. Jan 9 1923

20-UNDERTAKER. Burkhart Zirkler

ADDRESS 1739 Eager

Is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70940

CERTIFICATE OF DEATH.

90 D70940

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 619 S. Decker Ave, ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Deickman

(a) RESIDENCE NO. 619 S. Decker Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 10 mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Deickman

6 DATE OF BIRTH (month, day, and year) Feb. 16. 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy-Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Adolph Kahlert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Batz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisville, Ky.

14 Informant John Kahlert (Address) 619 S. Decker Ave.

15 Filed 1923, 19 Robert F. Ellison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6. 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1922, to Jan 6, 1923, that I last saw h[illegible] alive on Jan 6, 1923, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Harold B. Tilton M. D.

1/7, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL Jan 10 1923

20 UNDERTAKER Frokler & Frokler — ADDRESS 1739 E. Fayette

TICN is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D70941

HEALTH DEPARTMENT—CITY OF BALTIMORE

164 D70941

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 S Front St., 3 WARD)

2-FULL NAME Francisco Lauro

(a) RESIDENCE NO. 9 S Front St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28, 1826

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	96	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Print Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Victor Lauro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mary Esportia

(Address) 9 S Front St

15 Filed ....., 19 ..... Registrar

1923

Robert F. Garfinkel

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1923

17 I HEREBY CERTIFY, That I attended deceased from (Various Times), 19 22, to Jan 8, 19 23.

that I last saw h..... alive on Jan 7, 19 23,

and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:

Senile Debility

..... (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Thornton M. D.

Jan 8, 19 23 (Address) #1405 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Catholic Cemetery — DATE OF BURIAL 1/9/1923

20 UNDERTAKER E. J. Fanning & Son — ADDRESS 1938 Lafayette Ave.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70942

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-00 D70942

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 230 S. Albemarle ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Broccolina

(a) RESIDENCE NO. 230 S. Albemarle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 9th 1922

7 AGE — Years: — Months: 7 — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Sebastine Broccolina

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Josephine Maladona

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Sebastine Broccolina

(Address) 230 S. Albemarle St.

15 Feb 1923, 19 Robert F. Garrison, Registrar

Chief Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922 to Jan 7, 1923.

that I last saw he alive on Jan 7, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm F Kalafuss M. D.

, 19 (Address) 1038 W Fredrick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Jan 9th 1923

20 UNDERTAKER: Wendel, Rippel & Son — ADDRESS: 37 S. Conant St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70943 100-001 D70943

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mantebello Terrace & Fleming St. WARD) nurse

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Cavana

(Residence in Baltimore: No. Mantebello Terrace & Fleming St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
F	W	Single

6-DATE OF BIRTH, Oct 11, 1896 (Month) (Day) (Year)

7-AGE, 26 yrs. 2 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar Cutter
(b) General nature of industry, business, or establishment in which employed (or employer): Clipper

9-BIRTHPLACE, (State or Country), Baltimore city

PARENTS.

10-NAME OF FATHER, [redacted] Cavana

11-BIRTHPLACE OF FATHER (State or Country) Italy

12-MAIDEN NAME OF MOTHER Margaret Fiorini

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Fiorini

(Address) Mantebello Terrace

15-

Filed....., 191.....

Registrar.

1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 5, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1-2 1923, to 1-5 1923, that I saw h[redacted] alive on 1-5 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration) ....yrs. ....mos. 9 ds.

(Signed) Mary J. Cavanaugh M. D.

1-7, 1923 (Address) 1038 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincents

DATE OF BURIAL, Jan 9th, 1923

20-UNDERTAKER Leo G. Cook

ADDRESS North & Harford Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70944 11-001 D70944

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 Eastern Av. ST.; 2d WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Thomas

(Residence in Baltimore: No. 1806 Eastern Av. St.; 61 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, (Month) Jan. (Day) 15, (Year) 1861

7-AGE, Over 61 yrs. 11 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Store Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) Candy Store

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Stein

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Clara Schroeder

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John Hilgen

(Address) 1130 E. Lexington St.

15- Robert F. Garrison, Special Permit Clerk.

Filed ....., 191.....

1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) January (Day) 7th, (Year) 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 8th 1922, to Jan 7th 1923, that I saw h Er alive on Jan 7th 1923, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Influenza

followed by General Exhaustion

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(Duration) ....yrs. ....mos. ....ds.

(Signed) Herman J. Siems M. D.

Jan. 7th, 1923 (Address) 1200 Eastern Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Jan. 11, 1923

20-UNDERTAKER George L. Schwab

ADDRESS 701 Fulton Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70945

CERTIFICATE OF DEATH.

90 D70945

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Blue

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	? 46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Municipal Hospital Records (Address)

15 1329 ....., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 5 19 23

17

I HEREBY CERTIFY, That I attended deceased from January 4, 19 23 to January 5, 19 23,

that I last saw him alive on January 4, 19 23,

and that death occurred, on the date stated above, at 6:50 A.M.

The CAUSE OF DEATH* was as follows:

Heart Failure

Acute

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. A. Mucko M. D.

1/6/ 19 23 Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 1/8 19 23

20 UNDERTAKER

ADDRESS

Robert F. Garrison, Commissioner of Health

Deputy Clerk

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D70946

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70946

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Cortney Rd ST.; 27 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Brown

(Residence in Baltimore: No. 518 Cortney Rd St.; .....yrs., ...mos. 1/4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Fem	white	Single

6-DATE OF BIRTH, Jan 8, 1923 (Month) (Day) (Year)

7-AGE, ...yrs. .....mos. 1/4 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph Aloysius Brown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Anne Fitzsimmons

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph A. Brown Jr.

(Address) 518 Oakney Ave

15- Jan 9, 1923 ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 8, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 8. 1923, to Jan 8 1923, that I saw h[illegible] alive on Jan 8 1923, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Bronchial trouble 1 yr Dr

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

..... (Duration).....yrs.....mos.....ds.

(Signed) Geo. H. Broome M. D.

Jan 8, 1923 (Address) 5835 York Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Cem Govans Md — DATE OF BURIAL, Jan 9th, 1923

20-UNDERTAKER Wm J Hartwell — ADDRESS 2256 N. Baltimore St.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D70947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70947

CERTIFICATE OF DEATH.

101-00

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2223 Division St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Weil

(a) RESIDENCE. No. 2223 Division St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Coard

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 62 Years — Months — Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Joseph Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant (Address): Rodney Reed 2223 Division St

15 Filed . 19 Registrar

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 31st, 1923, to Jan 6th 1923

that I last saw h[illegible] alive on Jan 6th 1923

and that death occurred, on the date stated above, at 6.40A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Geo. H. Feuerbach M. D.

1-6, 19 (Address) 2215 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 9 1923

20 UNDERTAKER: Jno A. Toadvine ADDRESS 1142 W. Fayette St.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70948

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D70948

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

2-FULL NAME Theodora Maciejewska (Theodora Maciejewska)

(a) RESIDENCE NO. 732 S. Bond ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 40 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	89			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mary Kwaska

15 1923 Robert P. Harrison, ..., 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-6-1923

17 I HEREBY CERTIFY, That I attended deceased from 1-3-, 1923 to 1-6-, 1923

that I last saw h... alive on 1-6-, 1923

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas. Powell M. D.

, 19 23 (Address) 1 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: 1/10 1923

UNDERTAKER: Wm Faelsowski

ADDRESS: 1608 Eutaw

TION is very important. See instructions on back of certificates.

(See Letter Attached)

D70949

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70949

CERTIFICATE OF DEATH.

24 101-00

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1319 Andre St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Adam Jadrawicz. 20 ---------

(Residence in Baltimore: No. 1319 Andre St. St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. ..... Do not know. ..... 1.....
(Month) (Day) (Year)

7-AGE. 40 42 yrs. ---- mos. ---- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)..... N.D.

9-BIRTHPLACE, (State or Country). Poland,

PARENTS.

10-NAME OF FATHER, Joseph Jadrawicz,

11-BIRTHPLACE OF FATHER, (State or Country). Poland.

12-MAIDEN NAME OF MOTHER, Tillie Orshawicz.

13-BIRTHPLACE OF MOTHER, (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Jadrawicz. (brother)

(Address)..... 1351 Andre St.

15-

Filed ..... 192.....

1923 Robert P. Harrison,

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 7th. 1923. 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... inquiry .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Lobar Pneumonia. .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Jany. 8th 1923 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Rosary Cem	Jan. 10. 1923
20-UNDERTAKER,	ADDRESS
Wm Fialkowski	1618 Eastern Ave

If any important. See instructions on back of certificate.

TELEPHONES
C & P SOUTH 1093
MD. HENRIETTA 87

DR. OTTO M. REINHARDT.
1017 S. CHARLES ST.,

Coroner's Office
SOUTHERN DISTRICT

OFFICE-HO
8
2
6

BALTIMORE, MD. D 709

January 11th, 1923.

Dr. C. Hampson Jones.
Commissioner of Health.
Baltimore, Maryland.

Dear Doctor;

On the certificate of death of Adam Jadrawicz #1319 Andre St., who died January 7th, 1923, of Lobar Pneumonia, I stated his age as 42years, this is incorrect and should have been 40 years. Will you kindly have the above correction made on the certificate and oblige,

Yours truly,

Otto M. Reinhardt M.
Coroner

OMR/CR.

Spec.—1-10-21—M&T—1500 Bks.

D70950 HEALTH DEPARTMENT—CITY OF BALTIMORE D70950

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 772 ave Henry ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Haffenbach

(a) RESIDENCE NO. No 772 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 7 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	40	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Arnold F. Haffenbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna E. Trent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) William Haffenbach 772 ave McHenry

15 Jan 10 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1922, to Jan 6, 1923, that I last saw h alive on Jan 6 11 P m 1923, and that death occurred, on the date stated above, at 3.40 A m.

The CAUSE OF DEATH* was as follows:

Chr. Endo-Carditis, with insufficiency of mitral & aortic Valves

(duration) some 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema and Anasarca

asthenia (duration) ✓ yrs. 3 mos. ✓ ds.

18 Where was disease contracted if not at place of death? Bacto

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Phys diagnosis

(Signed) Robert W. Mifflin, M. D.

January 1923 (Address) 1016 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Jan 10 1923

20 UNDERTAKER Jos Freedenberg Son — ADDRESS 2173 Bks

TION is very important. See instructions on back of certificates. ... may be properly classified. Exact statement of OCCUPATION ...

Spec.—1-10-21—M&T—1500 Bks.

D70951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70951

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3958 Falls Road ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Knight

(a) RESIDENCE No. 3958 Falls Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 6 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. J. Knight

6 DATE OF BIRTH (month, day, and year): June 8-1864

7 AGE — Years: 58 — Months: 6 — Days: 30 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Perry A. Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co. Maryland

12 MAIDEN NAME OF MOTHER: Mary Dolby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mrs. Laura E. Knight 3958 Falls Road

15 Filed ..... 19 ..... Registrar

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 8 1922 to Jan 7 1923.

that I last saw h[illegible] alive on Jan 7 1923

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma abdomen.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Hysterectomy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? about

Did an operation precede death? Yes Date of Oct 15/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

19 [illegible] Address 3532 Rolandon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's (Hampden) — DATE OF BURIAL: Jan. 10 1923

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 3631 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70952

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D70952

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Druid Hill Ave. ST.: 27 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Noah Martin

(Residence in Baltimore: No. 1213 Lake ave. St.; (3) yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX. Male

4 COLOR OR RACE. White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) M

6 DATE OF BIRTH, May (Month) 22 (Day), 1837 (Year)

7 AGE, 85 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8 OCCUPATION: (a) Trade, profession, or particular kind of work Carpenter & Cabinet Maker (b) General nature of industry, business, or establishment in which employed (or employer) Retired 14 years

9 BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10 NAME OF FATHER, Unknown

11 BIRTHPLACE OF FATHER (State or Country). Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country), Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Maggie E. Martin

(Address) 3615 Gelds Road

15 Robert F. Harrison, Filed ....., 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH, Jan 7 (Month) (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Duration 26 yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (Duration) .....yrs.....mos.....ds.

(Signed) ..... M. D. (Coroner.)

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL, Lone Oak

DATE OF BURIAL, Jan 9, 1923

20 UNDERTAKER Horace H. Burgee

ADDRESS 363 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C 8 1923

Spec.—1-10-21—M&T—1500 Bks.

D70953

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D70953

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 901- N. Gay St ST., 10 WARD)

2-FULL NAME Wm. Edward Peregoy.

(a) RESIDENCE NO. 901- N. Gay St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/27/22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Frank J. Peregoy

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Lucy Mates

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Frank J. Peregoy
(Address) 901- N. Gay St

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from January 4th, 1923, to January 8th, 1923,

that I last saw h alive on January 4th 1923.

and that death occurred, on the date stated above, at 7.45 A.M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) ... yrs. ... mos 7 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. H. Stokes, M. D.

Jan 8, 1923 (Address) 1735 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	1/9 1923
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70954

D70954

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 2610 Greenmount Ave

CITY OF BALTIMORE: (No. Southern Caneer Hos ST., 12 WARD)

2-FULL NAME Mary Rountree

(a) RESIDENCE NO. 2310 Greenmount Ave ST., Southern Caneer Hos WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry C. Rountree

6 DATE OF BIRTH (month, day, and year): 3/17 1857

7 AGE: Years 65; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Southern Caneer Hosp Records

15 Filed ....., 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jun 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1921, to Jun. 6, 1923, that I last saw h[illegible] alive on Jun. 6, 1923, and that death occurred, on the date stated above, at 6 00 P. m.

The CAUSE OF DEATH* was as follows:

1) Chr. nephritis.

2) Apoplexy

(duration) 1 yrs. 10 mos ..... ds.

CONTRIBUTORY (Secondary): Myocardial insuff.

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dudley P. Bowe, M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: 1/10/1923

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70955 (Albers) 159-002 D70955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 1732 Townsend ST. Place (W. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis X Albers

(Residence in Baltimore: No. 1732 Townsend Place Str.) ..... yrs., mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) divorced

6-DATE OF BIRTH. Dec. (Month) 24 (Day), 1922 (Year)

7-AGE, ... yrs. ..... mos. 13 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER. Henry Albers

11-BIRTHPLACE OF FATHER (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER. Eliz. Colleson

13-BIRTHPLACE OF MOTHER (State or Country) Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Albers

(Address) 1732 Townsend Pl.

15-

Filed ....., 191.....

..... Registrar.

1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 7 (Day), 1923 (Year)

I HEREBY CERTIFY, That I attended deceased from Dec. 24 1912 to Jan 7 1923, that I saw h— alive on Jan 6 1923 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Asphixia Fatal

..... (Duration) ..... yrs. 0 mos. 13 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Rumbock M. D.

1-7, 1923 (Address) 1531 Mott Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St Vincent Cemtery.

DATE OF BURIAL, Jan 10, 1923

20-UNDERTAKER George J. Ruth

ADDRESS 1705 Harford

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70956

CERTIFICATE OF DEATH.

74-001 D70956

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 W. Saratoga ST., 4 WARD)

2-FULL NAME Rosie Fonti

(a) RESIDENCE NO. 614 W. Saratoga ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Joseph Fonti.

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years 82 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): Italy.

PARENTS

10 NAME OF FATHER: Joseph Gulfi

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy.

12 MAIDEN NAME OF MOTHER: Rosie Liberto

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy.

14 Informant: Mrs. V. Liberto
(Address): 614 W. Saratoga St.

15 Filed ....., 19 ..... Registrar

Robert P. Garrison, Chief Clerk. Daniel Perrill Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1922, to Jan 5th, 1923, that I last saw her alive on Jan. 7th, 1923, and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 15 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Harry M. Rautenberg, M. D.

, 19 (Address) 732 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Jan. 9th 1923

20 UNDERTAKER: Geo. L. Routh

ADDRESS: 1735 Harford Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70957

D70957

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 N. Luzerne Ave. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Griggs

(a) RESIDENCE NO. 4 N. Luzerne Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret V. Griggs

6 DATE OF BIRTH (month, day, and year) Dec. 14, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 162

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. O. Griggs

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Margaret V. Griggs
(Address) 4 N. Luzerne Ave.

15 Filed ....., 19 ..... Robert P. Garrison, Registrar

1923 Deputy Health Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 6 1923

17 I HEREBY CERTIFY, That I attended deceased from August, 1922 to Jan 6, 1923, that I last saw h[illegible] alive on Jan 6, 1923 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cardiac[illegible] of Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Greer, M. D.

1/8, 1923 (Address) 2600 E Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Jan. 9, 1923
20 UNDERTAKER	**ADDRESS**
Wm. C. Black,	927 N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70958 D70958

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 Collins Ave ST., 20 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Fagret Jebbers

(a) RESIDENCE NO. 115 Collins Ave ST., ... WARD 20

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Jebbers

6 DATE OF BIRTH (month, day, and year) Dec 12 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hair Dresser

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

186

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Fred Sauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Sueta Sauer

(Address) 1806 Hollins St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7 1923

17

I HEREBY CERTIFY, That I attended deceased from January 6, 1923, to January 7, 1923,

that I last saw h[er] alive on January 7, 1923,

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

..... (duration) ..... yrs. ..... mos 1 ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Not

(Signed) Henry J Kahn, M. D.

1/8, 1923 (Address) 723 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemty	Jan 9a 1923
20 UNDERTAKER	ADDRESS
Geo Leimbach & Son	624 W Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D70959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70959

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 38 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Rea

(a) RESIDENCE. No. Mt Hope Retreat ST., 28 WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Dont know yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Widow of Mr Rea

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	90	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) (?) Ireland

PARENTS

10 NAME OF FATHER James Quinn

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ford

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland

11 Informant Records of Mt Hope Retreat

(Address) Mt Hope Md

13 Filed , 19 Registrar

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7th 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 30 1892 to Jan 7th 1923

that I last saw h alive on Jan 7th 1923,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Disease of the Heart (Mitral)

abt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Primal Pneumonia Post Hemorrhagia (duration) 30 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Jan 9th 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

8

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70960

CERTIFICATE OF DEATH.

90 D70960

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home Infy ST., (Ward)

2-FULL NAME Emilie Munder

(a) RESIDENCE NO. 2750-Md-Ave ST., 12 WARD (Resident)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? 86 yrs. 9 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theophilus Munder

6 DATE OF BIRTH (month, day, and year) March-28-1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) ..... none

(c) Name of employer ..... none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jos. Underwooden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Sophia Harig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rotterman Germany

14 Informant (Address) Mrs May M. Slack (daughter) 2750-Maryland-Ave

15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1923, to Jan. 7, 1923

that I last saw h[illegible] alive on Jan. 7, 1923,

and that death occurred, on the date stated above, at 12[illegible]5 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cholelithiasis, Cholecystitis, Chron. Int. Obs. (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? Yes. Date of Jan. 1, 1923

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) Richard F. Corbett M. D.

, 19 (Address) Church Home & Infy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park Cemetery DATE OF BURIAL Jan 9/ 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

8

Spec.—1-10-21—M&T—1500 Bks.

D70961

HEALTH DEPARTMENT—CITY OF BALTIMORE

83

D70961

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 607 N Charles ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Clayton

(a) RESIDENCE NO. 607 N Charles ST., 11 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 79 yrs. 11 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Jan-22-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Anne Arundel County Md

PARENTS

10 NAME OF FATHER: Geo Clayton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anne Arundel County Md

12 MAIDEN NAME OF MOTHER: M Louise Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundel County Md

14 Informant (Address): Mrs E. G. Taylor (Sister) 607 N Charles St

15 Filed 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-7-1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 30 1922, to Jany 7th 1923, that I last saw her alive on Jany 7th 1923, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Softening (Senile) of Brain

Ill (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Concussion (duration) yrs. Fracture mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Elsie Clayton, M. D.

, 19 (Address) 607 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Jan 9 - 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70962

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70962

101-60

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 Woodlawn Rd ST., 27 WARD)

2-FULL NAME Mary Boehm

(a) RESIDENCE NO. 401 Woodlawn Rd ST., 27 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? 68 yrs. 1 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov-13-1854

7 AGE — Years: 68 — Months: 1 — Days: 25 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Wolfgang Boehm

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Schrettle

13 BIRTHPLACE OF MOTHER (city or town) Berlin (State or country) Germany

14 Informant Miss Luhild Wilhelmine Boehm (Address) 401 Woodlawn Rd

15 Filed 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/7 19 23

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 19 23, to Jan 8, 19 23, that I last saw h[illegible] alive on Jan 7, 19 23, and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows: Pneumonia (Lobar)

(duration) ..... yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hypostatic

(duration) 5 yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Henry F. Reedy M. D.

1/8, 19 23 (Address) 1 Upton Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Jan-9 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AV

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D70963

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70963

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2744 Fenwick Av. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Herring

(a) RESIDENCE NO. 2744 Fenwick Av ST., 9 WARD (Resident)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? 83 yrs. 3 mos. 23 ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept-16-1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	83	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Herring

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louisa Lowry

13 BIRTHPLACE OF MOTHER (city or town) Phila. (State or country) Penna

14 Informant Mrs Jno S. Bayless (Brotherin) (Address) 2104 Eutaw Pl

15 Filed ....., 19.... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1922, to Jan 8, 1923, that I last saw her alive on Jan 8, 1923 and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Chr. valvular Heart Disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harold W. Wood M. D.

1/8, 1923 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Jan 10 1923

20 UNDERTAKER STEUART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70964

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr Parker

101-001 D70964

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 6 to 6 33rd St ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Ruckle

(a) RESIDENCE. No. 6 to 6 33rd ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos E. Ruckle

6 DATE OF BIRTH (month, day, and year) Unknown 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	72	+	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER James Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Ada S. Ruckle

(Address) 6 to 6 33rd St

15 JAN 9 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from January 2nd, 1923 to January 5th, 1923, that I last saw h.W. alive on January 5th, 1923, and that death occurred, on the date stated above, at 6.35 p. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia, Chronic lung

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Shirley Perkins, M. D.

, 19 (Address) 1 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gathland Cemetery	Jan 9, 1923

20 UNDERTAKER Chas. H. Evans & Son

ADDRESS 118 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70965

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-00 D70965

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 Leadenhall St. 23 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Cuff

(a) RESIDENCE. No. 909 Leadenhall St., 23 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col'd	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	-	-	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Whitewasher

(c) Name of employer ~~Self~~.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant J. H. Brune
(Address) 1811 N. Monument St

15 JAN 9-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/6/1923

17 I HEREBY CERTIFY, That I attended deceased from 8/15/22, to 1/8/23, that I last saw h[e] alive on 1/7/23, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart about 3 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis about 1 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Jno Gordon, M. D.

1/8, 1923 (Address) 908 Leadenhall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ct	Jan 9 1923
20 UNDERTAKER	ADDRESS
J. H. Brune & Son	1811 N. Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179

D70966

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 913 S. Sharp St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillie Langley. (C)

(Residence in Baltimore: No. 913 S. Sharp St. St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	Colored	Married.

6-DATE OF BIRTH, Do not know. (Month) (Day) 1..... (Year)

7-AGE, 34 yrs. ---------- mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None. 87
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Portsmouth, Va.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Langley. (C) husband.

(Address) 913 S. Sharp St.

15- Filed JAN 9 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 5th. 1923 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental burns about the body. Upsetting of an oil lamp.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) C.....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto Reinhardt M. D. (Coroner)

Jany. 6th 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Laurel et — DATE OF BURIAL. Jan 7 1923

20-UNDERTAKER. L. H. Brown & Son — ADDRESS Del. R. Route 5

Is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70967

CERTIFICATE OF DEATH.

179 D70967

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 South Bouldin ST., Ward)

2-FULL NAME Ida May Curry

(a) RESIDENCE No. 120 S. Bouldin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Curry

6 DATE OF BIRTH (month, day, and year) July 1 1880

7 AGE Years 42 Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Herman Winkleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hofnagel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Robert Curry (Address) 120 S. Bouldin

15 JAN 9 - 1923 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/9 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/23, 1922, to 1/9, 1923, that I last saw h alive on 1/6, 1923, and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Chr. Lobar Nephritis. Chr Myocarditis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Feldenheimer M. D.

1/8, 1923 (Address) 3323 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel DATE OF BURIAL Jan 10 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70968

CERTIFICATE OF DEATH.

90 D70968

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Oswego ave Registration Rd 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia A Woodall

(Residence in Baltimore: No. Oswego ave Registration Rd St. Lbs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-~~SINGLE, MARRIED, WIDOWED OR DIVORCED,~~ (Write the word.) Widow

6-DATE OF BIRTH, August (Month) 1 (Day) 1 (Year)

7-AGE, 61 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James Buckey

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Mary Anna Deffery

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sadie McCauley

(Address) Oakland Farm

15- Filed JAN 9 - 1923, 191..... ROBERT R. KRAUTER, Clerk.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 8 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1921, to Jan 7 1923, that I saw her alive on Dec 27 1922, and that death occurred, on the date stated above, at 12.20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leonard E Beach M. D.

Jan 7, 1923 (Address) 2231 St. Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Jan 10., 1923

20-UNDERTAKER William Cook — ADDRESS 502 E North Ave

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D70969

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70969

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 915 N. Bentalou ST., 16 WARD)

2-FULL NAME Spencer J. Robinson

(a) RESIDENCE NO. 915 N. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E Robinson

6 DATE OF BIRTH (month, day, and year) Aug. 14 1838

7 AGE — Years: 84 — Months: 4 — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Traveling Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Sarah Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs. Mary E Hand (Address) 915 N Bentalou

15 Filed JAN 9 - 1923, 19 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1920, to Jan 8, 1923.

that I last saw h[illegible] alive on Jan 6, 1923

and that death occurred, on the date stated above, at 9 45 a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Duration about 3 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Leo Heller Jr. M. D.

1/8/23 (Address) 1937 Vaughn St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Jan 11 1923

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Beltrio Ponzoli ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

36-005

D70970

D70970

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Morris Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1122 N. Mount ST. 10 WARD)

2-FULL NAME Beltrio Ponzoli

(a) RESIDENCE NO. 1026 Brentwood Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Ponzoli

6 DATE OF BIRTH (month, day, and year) 6/22/1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Maria Ponzoli
(Address) 1026 Brentwood Ave.

15 JAN 9-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-6-1923

17 I HEREBY CERTIFY, That I attended deceased from 10-19, 1922, to 1-6-, 1923.

that I last saw h[illegible]alive on 1-6-, 1923

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Kidney

(duration) 3 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Operative Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 1-5-23

Was there an autopsy? no

What test confirmed diagnosis? [illegible]

(Signed) Howard Folsom M. D.

, 19 (Address) 1122 N Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL 1/9 1923

20 UNDERTAKER George J. Ruth ADDRESS 1735 Hanford Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70971

CERTIFICATE OF DEATH.

124 D70971

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 S Bouldin ST., No WARD)

2-FULL NAME Minnie Clayton

(a) RESIDENCE No. 113 S Bouldin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm E Clayton

6 DATE OF BIRTH (month, day, and year): Feby 9. 1874

7 AGE: Years 48 Months 10 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Louis Ritter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: W E Clayton

(Address): 113 S Bouldin

15 Filed JAN 9 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1922, to Jan 7th, 1923, that I last saw her alive on Jan 7th, 1923, and that death occurred, on the date stated above, at 1 00 P m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Embolus

(duration) yrs. mos. 2 hrs.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robt. S. Kirk, M. D.

1/8, 1923 (Address) 3126 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Jan 10 1923

20 UNDERTAKER: John Ulrich — ADDRESS: 200 Balcom

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70972

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00

D70972

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3311 E Pratt ST., 1 WARD)

2-FULL NAME Margeretha Elizabeth Huether

(a) RESIDENCE NO. 3311 E Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Huether

6 DATE OF BIRTH (month, day, and year): Jan 17-1829

7 AGE — Years: 93 — Months: 11 — Days: 20 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Adam Heller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: H. A. Ryll (Address): 3311 E Pratt St

15 Filed: JAN 9-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 6, 1923, that I last saw her alive on Jan 6, 1923, and that death occurred, on the date stated above, at 12 30 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Allen C Beecham, M. D.

1-8, 1923 (Address) 3139 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: Jan 9 1923

20 UNDERTAKER: John Ullrich

ADDRESS: 800 E Lan

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D70973

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Webster Fields

(a) RESIDENCE NO. 126 W. Pleasant st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Joseph Fields

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M. T. H.

15 JAN 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1923, to Jan. 6, 1923,

that I last saw him alive on Jan. 6, 1923,

and that death occurred, on the date stated above, at 4.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mns. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde O'Neil M. D.

1-6-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shark Hall-Richmond Co. Va. DATE OF BURIAL Jan 8 1923

20 UNDERTAKER Daniel Easton ADDRESS 916 E. Fayette.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70974 HEALTH DEPARTMENT—CITY OF BALTIMORE D70974

66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 226 So. Eden St., 3 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Charles L. Grodr

(Residence in Baltimore: No. 726 So. Eden St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Unknown ..... 1..... (Month) (Day) (Year)

7-AGE. 52 about yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....mdn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Auto Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), R. I.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15- JAN 9 - 1923 192. ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 25th, 192.2 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest. (Inquest or Inquiry.) thereon and from the evidence obtained by said Inquest, and from the Autopsy (Autopsy or Inquiry.) find that said deceased came to.....

on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Thos. B. Horton M. D.

Jan 8th 1923 (Coroner) (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Balto. Pike

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park.	1/9 192.3

20-UNDERTAKER. John O Mitchell ADDRESS 1701 W. Fayette St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70975

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D70975

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ..... St. Robinson WARD)

2-FULL NAME Alexander

(a) RESIDENCE NO. 304 Wilkington Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie A. Robinson

6 DATE OF BIRTH (month, day, and year) July 21. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Alexander Robinson

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary.

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) .....

14 Informant Lottie A. Robinson (Address) 304 Wilkington Ave.

15 Filed JAN 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 2. 1923 to Jan 8 1923

that I last saw h[e] alive on Jan 8 1923

and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate Gland

Acute Edema-

Contusion

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? Old home

Did an operation precede death? No Date of —

Was there an autopsy? .....

What test confirmed diagnosis? Clinically stat.

(Signed) James Robertson M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jany 10. 1923
20 UNDERTAKER, John Mitchell	ADDRESS 28 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70976

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70976

CERTIFICATE OF DEATH.

197

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 423-E. 2 St. 12 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Boston C. Brooks.

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M.	C.	—

6-DATE OF BIRTH, Unknown, 1 (Month) (Day) (Year)

7-AGE, Unknown yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Unknown
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Price Lecht

(Address).....

15- Filed JAN 9-1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 31, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

THE CAUSE OF DEATH* was as follows: Gun Shot wound through chest Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Morrissey M. D. (Coroner.)

Jan 23, 1923 (Address) 3622 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

JAN 9 - 1923

MORGUE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D70977

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70977

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3114 Talbot St Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Gradey Thomas

(Residence in Baltimore: No. 3114 Talbot St St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	C	Widow

6-DATE OF BIRTH.

..... 1..... (Month) (Day) (Year)

7-AGE	If LESS than 1 day
80 yrs. mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Known

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-JAN 9 - 1923 Filed..... 192..... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Dec 29 (Month) (Day) 192 22 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

.....

.....

.....(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary).....

.....(Duration) yrs. mos. ds.

(Signed) G. E. Lauchheimer M. D.

Jan 3 1923 (Coroner) (Address) 4 E. Biddle

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	..... 19....

20-UNDERTAKER,	ADDRESS
	JAN 8 - 1923

Commissioner Health.

THE MORGUE

0030

Mr. Wm. E. Russell

Fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D70978

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D70978

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. I726 Aliceanna ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ADAM BOROWSKI,

(a) RESIDENCE No. I726 Aliceanna ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male,

4 COLOR OR RACE: White,

5 Single, Married, Widowed, or Divorced, (write the word): Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 8/23.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, MD.

PARENTS

10 NAME OF FATHER Peter Borowski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Katharine Pietrowiak,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) MD.

14 Informant (Address) Peter Borowski, I726 Aliceanna Street

15 JAN 9 - 1923 ROBERT R. KNAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923 to Jan 8, 1923,

that I last saw h alive on Jan 8, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. D. Gyson, M. D.

1/8/23, 19 (Address) 805 16 Aliceanna

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. DATE OF BURIAL: Jan 9, 1923

20 UNDERTAKER: M. F. Sadowski. ADDRESS: 705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70979 ✓ 31 D70979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Morrow Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil Frankhl

(a) RESIDENCE NO. None ST., — WARD Findlan J

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Finlan

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 86

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant Marine

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Findland

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) — (State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) — (State or country)

14 Informant Patients History (Address)

15 FILED JAN 9-1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7 1923

17 I HEREBY CERTIFY, That I attended deceased from 12-26, 1922 to 1-7, 1923,

that I last saw he alive on 1-7, 1923

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic & Physical

(Signed) P. E. Schools, M. D.

1-8, 1923 (Address) Morrow Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Trinity Cemetery DATE OF BURIAL 1/8. 1923

20 UNDERTAKER L. Levinson Bro ADDRESS 1127 E. Baltimore

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70980

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

106-001 D70980

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. 7 ST. 13 WARD)

2-FULL NAME Edwin Talbott.

(a) RESIDENCE NO. 3819 Fords Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M or C

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) Wife of~~: Lotta Talbott.

6 DATE OF BIRTH (month, day, and year): Sept 3 1883

7 AGE: Years 39. Months 4 Days 5. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Pierce Md.

PARENTS

10 NAME OF FATHER: William H. Talbott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Annie E. McMahon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Bay View Hospital

15 Filed JAN 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 31, 1922 to Jan 8 1923 that I last saw him alive on Jan 7 1923 and that death occurred, on the date stated above, at 7-00 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Paralysis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Autopsy

(Signed) N. Todd Swift M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: 1/10 1923

20 UNDERTAKER: Walter Davis

ADDRESS: 3307 Paine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70981

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70981

CERTIFICATE OF DEATH.

66

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 226 So. Eden St., 3 Ward)

(If death occurred in a hospital or Institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME John H. Kaiser

(Residence in Baltimore: No. 1313 E. Balto St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word)
Male	White	Single

6-DATE OF BIRTH. Unknown (Month) (Day) 1871 (Year)

7-AGE. 51 yrs. 4 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Printer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: John H. Kayser

11-BIRTHPLACE OF FATHER, (State or Country): Balto. Md

12-MAIDEN NAME OF MOTHER: Catherine Miller

13-BIRTHPLACE OF MOTHER, (State or Country): Balto, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna A. Buckless

(Address) 1607 E. Biddle St.

15- JAN 9 - 1923 192.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Dec 25th (Month) (Day) 192.2 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs....mos....ds.

(Signed) Thos. B. Horton M. D.
Coroner.

Jan 7th 1923 (Address) Curtis Bay,

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Balto. Md.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, Jan 9 1923

20-UNDERTAKER, Zickler & Zickler — ADDRESS 1739 Eager

*state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Helen Davis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70982

CERTIFICATE OF DEATH.

3V

D70982

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 240 W. Hoffman ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Davis.

(Residence in Baltimore: No. 240 W. Hoffman St.; 3 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. 1920 (Month) 1 (Day) (Year)

7-AGE. 2 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Operator
(b) General nature of industry, business, or establishment in which employed (or employer). Stores

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Williams Davis

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Ella Lewis

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. W. Robinson

(Address) 240 W. Hoffman St.

15-

FILED JAN 9—1923 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan 7th 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/28th 1922 to Jan 7th 1923, that I saw h[illegible] alive on Jan 7th 1923, and that death occurred, on the date stated above, at 2:40 a.m.

The CAUSE OF DEATH* was as follows:

Cancer Uterus - Cachexia

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. Lee Ellis M. D.

1/8, 1923 (Address) Ezlewood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Montgomery Co. Md

DATE OF BURIAL. Jan. 10, 1923

20-UNDERTAKER Jos. T. H. Rochester

ADDRESS 1413 Jefferson

Spec.—1-10-21—M&T—1500 Bks.

D70983

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70983

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 245 S. Caroline ST., 3 WARD)

2-FULL NAME Joseph Jagelski

(a) RESIDENCE NO. 245 S. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 25-1922

7 AGE: Years — Months 3 — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none. ad

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Bronislaus Jagelski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Victoria Iwanuchka

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Bronislaus Jagelski
(Address) 245 S Caroline St

15 JAN 9 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5th, 1923, to Jan. 9th, 1923.

that I last saw him alive on Jan 8th 1923

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) — yrs. — mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John H. Rehberger, M. D.

, 19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Holy Rosary Cem	Jan 11-23
20 UNDERTAKER	ADDRESS
Jacob Zwolinski	452 S Bond St

MARGIN SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70984

HEALTH DEPARTMENT—CITY OF BALTIMORE

94-001 D70984

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — CITY OF BALTIMORE (No. 22 White ave ST., Hamilton WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Pruett

(a) RESIDENCE NO. 22 White ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ James Pruett April 21 1846 Not Known

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 76 — Months: 8 — Days: 9 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John L. Burris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Mrs Burdan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr Pruett.

(Address) 22 White ave

15 Filed JAN 9 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1922, to Jany 7, 1923

that I last saw her alive on Jany 7, 1923

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Aortic Aneurysm)

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Rupture Aorta, 15 minutes

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Morris B. Green, M. D.

1923 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Jan 10 1923

20 UNDERTAKER: Henry Hoeck & Son — ADDRESS: 1301 E Eager St.

INSTRUCTIONS. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D70985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D70985

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2227 Washington Blvd ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Carson

(a) RESIDENCE NO. 2227 Washington Blvd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lif yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 7" 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	36	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Construction

(b) General nature of industry, business, or establishment in which employed (or employer) Work) 640

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER George M. Carson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Henry

13 BIRTHPLACE OF MOTHER (city or town) Dorchester (State or country) Md.

14 Informant Frank Carson

(Address) 1159 Ward St.

15 Filed JAN 9 - 1923 ROBERT R. KRAUSER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7" 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1922, to Jany 5 1923.

that I last saw him alive on Jany 5 1923.

and that death occurred, on the date stated above, at 3.15P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? yes

(Signed) Thos B Hall M. D.

1/8, 1923 (Address) Washington & Hamilton Ave Holleton Pl Ferry Rds.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Melville Ave Elmridge DATE OF BURIAL Jan 10 1923

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N Gilmor St

Notice should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D70986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23 × 90

D70986

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 166 W. West St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Keene. (C)

(Residence in Baltimore: No. 166 W. West St. St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH. Do not know. 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
58 yrs. ---------- mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer. 0+0
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Madison, Md.

PARENTS.

10-NAME OF FATHER. James Keene. (C)

11-BIRTHPLACE OF FATHER, (State or Country). Madison, Md.

12-MAIDEN NAME OF MOTHER. Harriet Monoky. (C)

13-BIRTHPLACE OF MOTHER, (State or Country). Madison, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lee Keene. (C) son.

(Address) 166 W. West St.

15-
Filed JAN 9 - 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 6th. 1923. 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

Jany. 8th 192 3. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
ant Cemetery	1923

20-UNDERTAKER.	ADDRESS
Edward Bryan	631 Orleans st

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1180 Hast Pitt

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70987

CERTIFICATE OF DEATH.

185 D70987

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2226 Eutaw Place ST.; 13 WARD)

2-FULL NAME Mrs Ada Pitt

(a) RESIDENCE. No. 2226 Eutaw Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Harford County
(State or country) Md.

PARENTS

10 NAME OF FATHER Nathan McKnew

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Northumberland

12 MAIDEN NAME OF MOTHER Ada McKnew

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lancaster

14 Informant H. R. Pitt Son
(Address) 2226 Eutaw Place

15 JAN 9 - 1923

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4th 1923 to Jan 7th 1923
that I last saw her alive on Jan 7th 1923
and that death occurred, on the date stated above, at 9 22 P m.

The CAUSE OF DEATH* was as follows:
Communited fracture left femur; Carcinoma of Breast.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) H Arthur Dooley, M. D.

, 19 (Address) 2226 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 10 1923
20 UNDERTAKER George J. Smith	ADDRESS 532 Hollins St

Md 5535

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70988

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D70988

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1102 W. Calhoun ST.: 16 WARD)

2-FULL NAME Ida Blackston

(a) RESIDENCE. No. 1102 W. Calhoun St. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colrd	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Blackston

6 DATE OF BIRTH (month, day, and year) June 7, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calhoun

12 MAIDEN NAME OF MOTHER Anna Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Florence Young (Address) 1102 W. Calhoun St.

15 JAN 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1923 to Jan 8 1923

that I last saw h.. alive on Jan 7 1923,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (duration) 2 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Age Prolonged Seizures (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Thos D Long M. D.

Jan 8, 1923 (Address) 1209 Belvedere St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Dale — DATE OF BURIAL Jan 9 1923

20 UNDERTAKER Wm. H. Case Son — ADDRESS 1400 Madison

Instructions: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lucie

Spec.—1-10-21—M&T—1500 Bks.

160066 +B70989

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

99-002 D70989

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith.

(a) RESIDENCE No. 751 Saratoga St. City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Carter Brown (friend.

6 DATE OF BIRTH (month, day, and year): April ? - 1873

7 AGE: Years 49; Months 8; Days ?; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. 40

(b) General nature of industry, business, or establishment in which employed (or employer): (4)

(c) Name of employer: (4)

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Terry Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country): (4) Md.

12 MAIDEN NAME OF MOTHER: Julian Hammon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): (4) Md.

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records

15 JAN 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1922 to Jan 7, 1923.

that I last saw him alive on Jan 7, 1923,

and that death occurred, on the date stated above, at 5-35 A.M.

The CAUSE OF DEATH* was as follows:

Asthmatic Bronchitis

(some years) (1 yr.)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute heart failure.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. R. Bagg, M. D.

1/9, 1923 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 1/11/23 19

20 UNDERTAKER: Sam. W. Chase-son — ADDRESS: 1400 Norker St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21—M&T—1500 Bks.

D70990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D70990

1-PLACE OF DEATH South Balto Gen. Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No. 1311 Light ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie O Thomas

(a) RESIDENCE NO. 417 S. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Melvin Thomas

6 DATE OF BIRTH (month, day, and year) Aug 15-1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo Hertmanowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Melvin Thomas

(Address) 417 S Chester St

15 Filed JAN 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 6 1923

17 I HEREBY CERTIFY, That I attended deceased from December 28, 1922 to January 6, 1923, that I last saw her alive on January 6, 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia, Pericarditis, Septic Parotitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) John A. O'Connor, M. D.

, 19 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Jan 10 1923

20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

Spec.—1-10-21—M&T—1500 Bks.

Dr. Walter A. Cox ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70991

CERTIFICATE OF DEATH.

11-001

D70991

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2510 Frederick Av ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Louise Harris

(a) RESIDENCE NO. 2510 Frederick Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept 2nd 1921

7 AGE: Years 1 Months 4 Days 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm. E. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Hattie L. Louise Bobbitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Wm. E. Harris 2511 Frederick Av

15 Filed JAN 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1 — 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923, to Jan 7, 1923, that I last saw her alive on Jan — 7, 1923, and that death occurred, on the date stated above, at 4 06 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Grip

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis Signs & Symptoms

(Signed) Walter A Cox, M. D.

(Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL 1923

20 UNDERTAKER: F. B. Wagner — ADDRESS 2336 Fleet Av.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70992

CERTIFICATE OF DEATH.

3 | D70992

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Municipal Tuberculosis Hospital ST., (WARD) 7th

2-FULL NAME Anna Vechio

(a) RESIDENCE NO. 1109 S. East ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Vechio

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Starkey

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Hickman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address) M. T. H.

15 Filed JAN 9 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1922, to Jan. 8, 1923, that I last saw her alive on Jan. 8, 1923, and that death occurred, on the date stated above, at 2.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Clyde M. Neil, M. D.

1-8-23, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Jan 9 1923

20 UNDERTAKER Jno C. Stiller — ADDRESS 2334 Jefferson St

MENTION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70993 HEALTH DEPARTMENT—CITY OF BALTIMORE D70993

CERTIFICATE OF DEATH. 43

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 S. Ellwood ave WARD 1)

2-FULL NAME John J. Laughlin

(a) RESIDENCE NO. 724 S. Ellwood ave ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Laughlin

6 DATE OF BIRTH (month, day, and year) Nov.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Coffee Works

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS:

10 NAME OF FATHER Bernard Laughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anny Manning

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire.

14 Informant (Address) James Laughlin 724 S. Ellwood ave

15 ROBERT P. HARRISON, Burial Permit Clerk. 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922 to Jan 7, 1923 that I last saw him alive on Jan 6, 1923, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue & Jaw

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of —

Was there an autopsy? [redacted]

What test confirmed diagnosis? —

(Signed) m J McAvoy, M. D.

1/8, 1923 (Address) 829 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 1/10/1923

20 UNDERTAKER J. J. Moran — ADDRESS 3000 E. Baltimore

9-1923

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70994

CERTIFICATE OF DEATH.

164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 Westphalia Pl. St., 24 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Leonhardt

(a) RESIDENCE. No. 1811 Westphalia Pl. St., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 70 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Andy Leonhardt

(Address): 1444 Battery Ave

15 Jan 9 1923, Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Jan 7, 1923

that I last saw her alive on Jan 6, 1923

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Intermittent of old age.

(duration) 1 yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. H. Campbell, M. D.

Jan 7, 1923 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Brooklyn	Jan 10 1923

20 UNDERTAKER: W. E. Cook — ADDRESS: 5 & E Nath

Burial Permit Clerk.

NOTE—Name of informant supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70995

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D70995

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 774 S. Robinson ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Stopkins

(a) RESIDENCE NO. 774 S. Robinson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Stopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Catherine Tunney.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John Stopkins.
(Address) 774 S. Robinson St.

15 [illegible] 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7th 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923, to Jan 7, 1923, that I last saw him alive on Jan 7, 1923, and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea + enteritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis Mohr M. D.

19 (Address) 301 S. Edmondson Ave City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Saint Mary Cem.

DATE OF BURIAL Jan. 10 1923

20 UNDERTAKER Lilly & Zeiler

ADDRESS 1038 N. Wolfe St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

9-1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70996

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 117

D70996

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. Univ. Hospital ST.: W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Arnold

(a) RESIDENCE. No. Glyndon Md. ST., WARD. Glyndon Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 28 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER George W Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Mae Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Hospital Records. (Address)

15 Filed Jan 8 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4 1923, to Jan. 8, 1923; that I last saw h alive on Jan 8, 1923 and that death occurred, on the date stated above, at 11 28A m.

The CAUSE OF DEATH* was as follows:

Post operative adhesions following appendectomy (1½ ago)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction (volvulus)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Jan. 4, 1923.

Was there an autopsy? No.

What test confirmed diagnosis? Oper. & Clinical History

(Signed) G. S. Costalley, M. D.

Jan 8. 1923 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury M E Cemetery	Jan 11 1923
20 UNDERTAKER Rustentown Md	ADDRESS
J F. Ebrie	Rustentown Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION. AGE should be stated EXACTLY. PHYSICIAN'S should state TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D70997

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70997

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 321 (St.) St Helena Ave (WARD) 26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Brundrett

(a) RESIDENCE. No. 321 St Helena Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of: Mary A. Brundrett

6 DATE OF BIRTH (month, day, and year): Sept 3, 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Baker

(b) General nature of industry, business, or establishment in which employed (or employer): 003

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: John Brundrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Dorothea Kron

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Henry Brundrett (Address) 321 St Helena Ave

15 Filed N 9-1923 Robert P. Mattson, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1922, to Jan 8, 1923, that I last saw him alive on Dec 12, 1922, and that death occurred, on the date stated above, at 11-00 m.

The CAUSE OF DEATH* was as follows:

1 Chron. Valv. Insufficiency

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Oswald Pilcher, M. D.

, 19 (Address) Emmitsburg, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem. Inwood — DATE OF BURIAL: Jan 11, 1923

20 UNDERTAKER: E. LeRoy Stiffler — ADDRESS: 125 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D70998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70998

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1637 Cuba ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Malone

(a) RESIDENCE NO. 1637 Cuba ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 3 mos. 14 ds. How long in U. S., If of foreign birth? 61 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 23, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	61	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Marine Surveyor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Under. Ins. Co. N. Y.

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Dan'l Malone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Jos. Malone 1608 E. Fort Ave.

15 Robert P. Harrison, Registrar

19 ..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1922, to Jan 6, 1923.

that I last saw him alive on Jan 6, 1923

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) laryngeal tuberculosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) Wm. Bleiger, M. D.

1/9, 1923 (Address) 1314 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: Jan. 10 1923

20 UNDERTAKER: Margaret G. Flynn

ADDRESS 1422 Light St.

JAN 9-1923

INSTRUCTIONS: Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D70999

101-001 D70999

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 Ellamont ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edwin Hood

(a) RESIDENCE NO. 1503 Ellamont ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12, 1920

7 AGE: Years 2 yrs Months 8 Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Charles Howard Hood

11 BIRTHPLACE OF FATHER (city or town) Howard Co. (State or country) Md

12 MAIDEN NAME OF MOTHER Jennie Cohen

13 BIRTHPLACE OF MOTHER (city or town) London (State or country) England

14 Informant Mr. Charles Howard Hood (Address) 1503 Ellamont st

15 Filed . 19 Robert F. Duffy Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922, to Jan 9, 1923

that I last saw h[illegible] alive on Jan 8, 1923,

and that death occurred, on the date stated above, at 2-30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Septic myocarditis

(duration) yrs. mos. 6. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms —

(Signed) Shashaman Barb M. D.

. 19 (Address) 731 Parkwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Jan 10 1923

20 UNDERTAKER: Jos Joerdens & Son — ADDRESS: 217 S. Paca st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

9 - 1923

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71000 D71000

CERTIFICATE OF DEATH.

7 90 REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 N. Durham ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Runge

(Residence in Baltimore: No. 825 N. Durham St.; 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1 (Year)

7-AGE, 94 ? yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Retired

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Joseph Runge

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Harding

(Address) 1037 N. Broadway St

15- Robert F. ..... 191.....

1923 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 7 (Day), 1923 (Year)

I HEREBY CERTIFY, That I attended deceased from Dec 1922 to Jan 7 1923, that I saw h[illegible] alive on Jan 7 191., and that death occurred, on the date stated above, at 9:15 p. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

..... (Duration) ..... yrs.

CONTRIBUTORY (Secondary) Senility Contributory

..... (Duration) ..... mos. ..... ds.

(Signed) ..... M. D.

1-9 ....., 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Hill

DATE OF BURIAL, Jan 11, 1923

20-UNDERTAKER [illegible]

ADDRESS 1906 Eastland

If DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Budaschat

D 71001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 71001

44 D71001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto and Payson Sts

CITY OF BALTIMORE: No German Aged Home ST.: 20 WARD)

2-FULL NAME Ferdinand Radsclat.

(a) RESIDENCE. NO. German Aged Home ST.,

(Usual place of abode) WARD.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wh	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Brown

6 DATE OF BIRTH (month, day, and year) Feb 14 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ernst Ad Radsclat

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mr Brown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant German Home Records

(Address) Balto and Payson Sts.

15 JAN 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7" 1923

17 I HEREBY CERTIFY, That I attended deceased from ..... 1921 to Jan 7th 1923, that I last saw him alive on Jan 6th 1923, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John H Duff. M. D

19 (Address) 1843 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Jan 10" 23 19

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N Balto St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-19—M. & K.—3,000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71002

CERTIFICATE OF DEATH.

11-001 D71002

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 McCulloh ST.; 11 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Dorothea Doellinger

(Residence in Baltimore: No. 1201 McCulloh St.; 70 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state carefully applied.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Oct (Month) 27 (Day), 1834 (Year)

7-AGE,	If LESS than 1 day,
88 yrs. 2 mos. 11 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Andrew Zinram

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER ? Kleinmund

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Frederick Doellinger

(Address) 5000 Fernside Ave

15-

JAN 10 1923 191.....

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 8 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 4 1923, to Jan 8 1923, that I saw her alive on Jan 7 1923, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (Duration) ....yrs. ....mos. 1 ds.

(Signed) Frances A. Carpenter M. D.

Jan 8..., 1923 (Address) 2101 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Jan. 11, 1923
20-UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71003

101-001 D71003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 117 W. Barre ST., 27 WARD)

2-FULL NAME Mary Estelle Dyson

(a) RESIDENCE NO. 117 W. Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Oct, 9, 1892

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
30	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work-

(b) General nature of industry, business, or establishment in which employed (or employer): work-

(c) Name of employer: at home.

9 BIRTHPLACE (city or town) (State or country): St Mary's Co. Maryland.

PARENTS

10 NAME OF FATHER: Francis J. Dyson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Charles Co. Maryland.

12 MAIDEN NAME OF MOTHER: Rose A. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Mary's Co. Maryland

14 Informant: Rose A. Langley

(Address): 117 W Barre St

15 Filed JAN 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan, 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec, 28, 1922, to Jan, 9, 1923.

that I last saw her alive on Jan, 8, 1923,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos 13 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no —

What test confirmed diagnosis? none.

(Signed) David Franklin M. D.

1/9, 1923 (Address) 1111 W - See Dr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pearson St Mary's Md

DATE OF BURIAL: Jan 11-23

20 UNDERTAKER: F. A. Krauser Son

ADDRESS: 703 Hanover

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71004

D71004

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1931 w. North Ave ST., 15 WARD)

2-FULL NAME Grace N. Ritchie

(a) RESIDENCE NO. 1931 w. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 19. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress-maker

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer own business

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Robert Ritchie

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary A Nicholson

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Geo T. Ritchie

(Address) 24 Adams St. W. Md

15 JAN 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 9 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1922 to Jan. 9, 1923.

that I last saw her alive on Jan. 9, 1923.

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R. C. Metz M. D.

Jan 9. 1923 (Address) 1903 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Jan. 12 1923

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1944 W. North Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71005

CERTIFICATE OF DEATH.

100-001

D71005

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1634 W. Mount ST.: 15 WARD

2-FULL NAME Dorothy Montgomery

(a) RESIDENCE. No. 1634 W. Mount ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? 1 yrs. 2 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: collark

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 25, 1921

7 AGE — Years: 1 Months: 2 Days: 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: non

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Robert Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Mary Montgomery

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant (Address): Mary Montgomery 1634 W. Mount St

15 FILED JAN 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st 1923 to Jan 7th 1923

that I last saw h er alive on Jan 7th 1923

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Geo. H. Lautenbach M. D.

(Address) 2215 N. Monroe Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt auburn — DATE OF BURIAL: Jan 10 1923

20 UNDERTAKER: R. L. Groll — ADDRESS: 1405 McElderry

Information should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Cate

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71006

CERTIFICATE OF DEATH.

D71006

1-PLACE OF DEATH Abbottston near Catonsville Pk. 11-20 REGISTERED NO.

CITY OF BALTIMORE: (No. Gorsuch Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac M. Cate

(a) RESIDENCE NO. Gorsuch Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
Male	White	Married (Widower)

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Charlotte A. Cate

6 DATE OF BIRTH (month, day, and year) Feby 6-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	84	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Financier

(c) Name of employer

9 BIRTHPLACE (city or town) Effingtow (State or country) New Hampshire

PARENTS

10 NAME OF FATHER Isaac Cate

11 BIRTHPLACE OF FATHER (city or town) Loath (State or country) Ruord.

12 MAIDEN NAME OF MOTHER Nancy Swarb

13 BIRTHPLACE OF MOTHER (city or town) Loathwood (State or country)

14 Informant Harrad Cate (Address) Gorsuch ave.

15 Filed JAN 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 19 23, to Jan 9, 19 23,

that I last saw h alive on Jan 9, 19 23,

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 2 yrs. mos 1 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Martin W. Cate, M. D.

1-10, 19 23 (Address) 220 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL 1-11 1923

20 UNDERTAKER Hennegan Fenlon & Howlo — ADDRESS Mitchell & Orchard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71007

159.002

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71007

CERTIFICATE OF DEATH.

REGISTERED No. D71007

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4341 N. Lakewood ave. ST., 6 WARD)

2-FULL NAME Alice A. Kavanagh

(a) RESIDENCE No. 4341 N. Lakewood ave. ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct-16-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Edward M. Kavanagh

11 BIRTHPLACE OF FATHER (city or town) City

(State or country)

12 MAIDEN NAME OF MOTHER Anna M. Hartman

13 BIRTHPLACE OF MOTHER (city or town) City

(State or country)

14 Informant Anna M. Kavanagh

(Address) 4341 N. Lakewood Ave

15 JAN 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8th 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1922, to Jan. 8, 1923,

that I last saw her alive on Jan. 8, 1923,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Anomaly of Heart - Patent foramen Ovale

(duration) yrs. 2 mos 23 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. J. Schmit, M. D.

1923 (Address) 701 N. Lakewood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic bom

DATE OF BURIAL 1/10/ 1923

20 UNDERTAKER J. J. Moran

ADDRESS 3000 E. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71008 HEALTH DEPARTMENT—CITY OF BALTIMORE D71008

CERTIFICATE OF DEATH. 74-00

1-PLACE OF DEATH S.E. cor. Ridgely & Mt. Winans REGISTERED NO.....

CITY OF BALTIMORE: No. ..... ST.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Johnson

(a) RESIDENCE. NO. ..... ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Reuben Johnson

6 DATE OF BIRTH (month, day, and year) Cert. 1870

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Essex Co. Va

PARENTS

10 NAME OF FATHER Benj. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Frances Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Acting Manager Winans

Filed JAN 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/6/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/5/ 1923 to 1/6/ 1923 that I last saw h alive on 1/6/ 1923 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Embolism of Brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congestion of Stomach

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. B. Hawkins, M. D.

1/8/ 1923 (Address) 1916 S. Ht. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	1/10 1923
20 UNDERTAKER Samuel Kemsley	ADDRESS 578 Bd. East

INSTRUCTIONS.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D71008

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71009

CERTIFICATE OF DEATH.

100-001

D71009

REGISTERED NO.

1-PLACE OF DEATH Bayview Hospital

CITY OF BALTIMORE (No. ... ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David D. Jones

(a) RESIDENCE NO. Unknown ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE — Years 83 — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

087

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Do

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Bayview Hospital (Address) Balto, Md.

15 FILED JAN 10 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9. 1923

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1922, to Jan 9, 1923.

that I last saw him alive on Jan 8, 1923

and that death occurred, on the date stated above, at 6.00 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Terminal)

(duration) yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) H. E. Edwards, M. D.

1/9/23 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Jan 11 1923

20 UNDERTAKER Zurbler & Zurbler — ADDRESS 1739 Eager

INFORMATION, WHAT SOEVER, REGARDING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71010

CERTIFICATE OF DEATH.

90 D71010

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 S. Ann ST.; 2 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Nowak

(Residence in Baltimore: No. 719 S. Ann St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, Jan 1 (Month) (Day), 1845 (Year)

7-AGE, 78 yrs. 0 mos. 8 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Nowak

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Mary Stogowska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss A. Nowak Daughter

(Address) 719 S Ann St

15 JAN 10 1923 Filed 191 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 9 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1922, to Jan 9 1923, that I saw h[illegible] alive on Jan 9 1923 and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Jan 9 1923 (Address) 801 N Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem. DATE OF BURIAL, Jany. 13, 1923.

20-UNDERTAKER M. F. Sadowski ADDRESS 705 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D71011

1-PLACE OF DEATH D71011 REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Hill

(a) RESIDENCE NO. 112 Corbin St. Corbin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary's Co., Maryland

PARENTS

10 NAME OF FATHER Harrison Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover Co. Maryland

12 MAIDEN NAME OF MOTHER Louisa Haunsen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Mary's Co. Maryland

14 Informant Municipal Hospital Record. (Address)

15 Filed JAN 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from December 31, 1922, to January 6, 1923,

that I last saw him alive on January 5, 1923,

and that death occurred, on the date stated above, at 8:45 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Hypertension (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical & X-ray

(Signed) Clyde McNeil M. D.

1/6, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

JAN 10 1923

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

73

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D71012

REGISTERED NO. D71012

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Frazier

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Municipal Hospital Records.

15 Filed JAN 10 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk.

0034.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6 19 23

17 I HEREBY CERTIFY, That I attended deceased from January 2, 19 23, to January 6, 19 23, that I last saw h[illegible] alive on January 6, 19 23, and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical history etc

(Signed) Clyde Mitchell, M. D.

1/8/, 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL JAN 10 1923 Commissioner Health.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. USE BLACK INK

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D71013

CERTIFICATE OF DEATH.

D71013

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 E. 28th St. ST., 12 WARD)

2-FULL NAME Emma Elizabeth Frank.

(a) RESIDENCE NO. 413 E. 28th St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ds. 8 How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1, 1923

7 AGE Years ..... Months ..... Days 8 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Earl Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Emma Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Mrs Emma Frank.
(Address) 413 E. 28th St

15 JAN 10 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1923, to Jan 9th, 1923, that I last saw her alive on Jan 9th, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.
(7 month Baby)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Examination and Parents Statement

(Signed) L. L. Gordy M. D.

, 19 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden — DATE OF BURIAL Jan. 10, 192

20 UNDERTAKER Richard F. Cooley — ADDHESS 438 E. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Nattman

HEALTH DEPARTMENT—CITY OF BALTIMORE

10

D71014

D71014

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2624 E Hoffman ST., 8 WARD)

2-FULL NAME George. Myers Nattman.

(a) RESIDENCE No. 2624 E Hoffman. ST., ... WARD .....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 10. 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Nattman

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Ruby Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant George. Nattman.
(Address) 2624 E Hoffman St

15 Filed JAN 10 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1923 to Jan 9, 1923

that I last saw him alive on Jan 9, 1923 and that death occurred, on the date stated above, at 4 40 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Respiratory Paralysis

(duration) ..... yrs. 1 mos. ..... ds.

Malignant Diphtheria

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) ..... M. D.

Jan 9 1923 (Address) 301 N Pat Davis

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 1-10 1923

20 UNDERTAKER: Thos Chas A G Rohde Co — ADDRESS: Darlington Md

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Soergel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71015 — CERTIFICATE OF DEATH. — 1801 — D71015

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 502 N London ave St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Caroline Soergel

(Residence in Baltimore: No. 502 N London ave St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Married

6-DATE OF BIRTH. Sept (Month) 8 (Day) 1847 (Year)

7-AGE. 73 yrs. 4 mos. 1 ds. If LESS than 1 day, ...hrs. or....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Hans Offenhayer

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Anna Stade

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. F. Nehrenz

(Address) 602 N London ave

15- FILED JAN 10 1923 ROBERT R. KNAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 9 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Consumption by Inanition
Accidental Gas
(Duration) ....yrs. mos 4 hrs

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) James M. Kemble M. D.
(Coroner.)

Jan 10 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State 50 yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Kingsville Md.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
St Pauls Cemetery 1 — 12 1923

20-UNDERTAKER. Thos Chas A G Rehdr ADDRESS 600 Darlington Ave

...—8-24-14—M. & T.—2000 Bks.

D71016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71016

CERTIFICATE OF DEATH.

14-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 Presstman ST.; 14 WARD)

REGISTERED No, C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel J. Joyce

(Residence in Baltimore: No. 512 Presstman St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, July 16, 1876
(Month) (Day) (Year)

7-AGE, 46 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Head Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): 070

9-BIRTHPLACE, (State or Country), Carrol Co Md

PARENTS.

10-NAME OF FATHER, John J Joyce

11-BIRTHPLACE OF FATHER (State or Country), Howard Co. Md

12-MAIDEN NAME OF MOTHER Kitzie Kelley

13-BIRTHPLACE OF MOTHER (State or Country), Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Joyce

(Address) 512 Presstman St

15-

Filed JAN 10 1923

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 8, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1923, to Jan 8 1923, that I saw h[illegible] alive on Jan 7 1923, and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin K. Ballard M. D.

Jan 8, 1923 (Address) 162 Mt Royal Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Jan 11, 1923

20-UNDERTAKER Mrs Robert A Elliott

ADDRESS 1723 Ashland Ave

CAUSE OF DEATH in plain terms, as that it may be properly classified. important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

See Letter attached

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71017

D71017

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 2233 Christian ST. 20 WARD)

2-FULL NAME Solomon Hantin

(a) RESIDENCE NO. 2233 Christian ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida —

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 52 Months 5 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher 68

(b) General nature of industry, business, or establishment in which employed (or employer): Hebrew School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Moses Hantin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Julia —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): J. Lewin 1439 E. Balto.

15 Filed JAN 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 10 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7th, 1923, to Jan 10, 1923.

that I last saw him alive on Jan. 9th, 1923,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Heart failure (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Examn.

(Signed) Harry Goldberg, M. D.

1/10, 1923 (Address) 2210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon Road — DATE OF BURIAL: Jan 10 1923

20 UNDERTAKER: Jacob Lewis — ADDRESS: 1439 E. Balto

TION is very important. See instructions on back of certificates.

D71018

CERTIFICATE OF DEATH.

REGISTERED NO. C 100-D 71018

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Hebrew Hospital St. 15 WARD)
(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Schreiber

(Residence in Baltimore: No. 2308 Reisterstown Rd. St.: Life yrs., mos., d

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~ (Write the word.): M

6-DATE OF BIRTH: April —, 1884 (Month) (Day) (Year)

7-AGE: 39 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Max Schreiber

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Freida Malka Schreiber

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Jack Leuis

(Address): 1439 E Balto St

15- Filed: JAN 10 1923 191... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: January 9, 192 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased fr
November 25 192? to January 9 192?
that I saw h im alive on January 9, 192?
and that death occurred, on the date stated above, at 9.30 P.
The CAUSE OF DEATH* was as follows:
Pulmonary Abscess
do
(Duration) yrs. 1 mos. 14

CONTRIBUTORY (Secondary) Cardiac Failure
(Duration) yrs. mos. 2

(Signed) Rose G. Ellman M.
Jan 9, 192? (Address) Jan 9/23 Hebrew Hosp,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. 1 mos. 12 ds. In the State Life yrs. mos.
Where was disease contracted, if not at place of death? Home
Former or usual residence 2308 Reisterstown Rd

19-PLACE OF BURIAL OR REMOVAL: Hebrew Wash Road
DATE OF BURIAL: 1/12, 192

20-UNDERTAKER: Jack Leuis
ADDRESS: 1439 E Balto St

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co. 1000 Bks.

D71019

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71019

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 Woodbourne Ave ST. 27 WARD) 100-08

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Earl Myers

(a) RESIDENCE. NO. 506 Woodbourne Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 28-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto - Md
(State or country)

PARENTS

10 NAME OF FATHER Henry R. Myers

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Beulah M. Hartley

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Wm Myers
(Address) 506 Woodbourne Ave

15 Filed 1923 Robert P. Harris
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1923, to Jan 10, 1923, that I last saw him alive on Jan 9, 1923, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Broncho
over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H W Wheeler, M. D.

, 19 (Address) 4739 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	1-11 1923
20 UNDERTAKER	ADDRESS
Robt Brooks & Son	Baltimore

AR 10 1923

PLAINLY, IN INK.—THIS IS A PERMANENT RD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71020

15-9609 Ca. No. D71020

CERTIFICATE OF DEATH.

X 65-001.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Toms

(a) RESIDENCE NO. Forrille, Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 Months ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Nov 18-1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Toms

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Bessie Brown

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed ....., 19 ..... Robert F. Harris, Burial Permit Clerk. Registrar

JAN 10 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10. 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 9. , 1922, to Jan 10. , 1923, that I last saw her alive on Jan 10. , 1923, and that death occurred, on the date stated above, at 6a. m.

The CAUSE OF DEATH* was as follows:

Acute lymphatic leukaemia

Indefinite - Two months +

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Examination

(Signed) H. H. Mecah, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmont Md. DATE OF BURIAL 1/10 1923

20 UNDERTAKER W J Tuhnes & Son ADDRESS Rutter Pa Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Coroner notified. Body released

Spec.—1-10-21—M&T—1500 Bks.

D71021

HEALTH DEPARTMENT—CITY OF BALTIMORE

+118-00 D71021

CERTIFICATE OF DEATH.

4

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

2-FULL NAME Jacob Rider

(a) RESIDENCE NO. Stewartstown Pa. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? 71 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 28, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71	71	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 030

(b) General nature of industry, business, or establishment in which employed (or employer) retired engineer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Rider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records (Address)

15 Robert P. Harrison, Registrar

Filed , 19

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10th 1923

17 I HEREBY CERTIFY, That I attended deceased from January 9, 1923, to Jan 10, 1923, that I last saw h in alive on Jan 10th, 1923, and that death occurred, on the date stated above, at 8:00 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction from strangulated left femoral hernia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Stewartstown Pa.

Did an operation precede death? yes Date of Jan 9, 1923.

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings & operation

(Signed) Eugene Mattern M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stewartstown Pa.

DATE OF BURIAL 1/10/23

20 UNDERTAKER Philip Henry

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 10 1923

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71022 D71022

CERTIFICATE OF DEATH.

38

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 Rutland Ave ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Coles

(Residence in Baltimore: No. 831 Rutland Ave St.; 11 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug (Month) 21 (Day), 1888 (Year)

7-AGE, 34 yrs. 5 mos. 18 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Steel Plant

9-BIRTHPLACE, (State or Country), Wakefield Va

PARENTS.

10-NAME OF FATHER, Rubin Cole

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Agnes Tucker

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Wilson (Friend)

(Address) 919 Shuter St

15-

Robert P. [illegible]

Filed ....., 191.....

1 0 1923 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 8 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 8 1923, that I saw him alive on Jan 6 1923, and that death occurred, on the date stated above, at 9.00 A m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lustie

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ralph J. Young M. D.

1/10, 1923 (Address) 1229 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Wakefield Va

DATE OF BURIAL. Jan 10., 1923

20-UNDERTAKER Mrs Robert A Ellis

ADDRESS 1725 Eastland Ave

D71023

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71023

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Josephs Hosp St., 7 Ward)

Registered No. C. 197

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Harry Ellison

(Residence in Baltimore: No. 604 N. Chapel St.; yrs. mos. ds.)

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AN 1 01923

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	S

6-DATE OF BIRTH. Dec 9 1905
(Month) (Day) (Year)

7-AGE. 17 yrs. mos. 28 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Butcher
(b) General nature of industry, business, or establishment in which employed (or employer). 040

9-BIRTHPLACE, (State or Country). Balto md

PARENTS.

10-NAME OF FATHER. Henry Ellison

11-BIRTHPLACE OF FATHER, (State or Country). St. Marys Co

12-MAIDEN NAME OF MOTHER. Gertrude Ames

13-BIRTHPLACE OF MOTHER, (State or Country). Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Ames Smith

(Address) 604 N. Chapel

15- Robert P. Harrison,

Filed 192

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 6 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hernia Humoralis - Strangulated was taken by Police Officer O'Leary who made arrest by operation yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Gallagher M. D.
(Coroner)

1-9 1923 (Address) 508 E Monta

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laural Cemetery DATE OF BURIAL, Jan 11 1923

20-UNDERTAKER, Jno Robert A Thomas ADDRESS 1723 Ashland Av

D71024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D71024

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 132 Eutaw ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Morrsey

(Residence in Baltimore: No. 30. 132 Eutaw St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	Col.	Married

6-DATE OF BIRTH, ..., 1868
(Month) (Day) (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Rag picker
(b) General nature of industry, business, or establishment in which employed (or employer) Odd

9-BIRTHPLACE, (State or Country), Africa

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Record from Neighbors

(Address) in the House Mrs Bates

15- Robert P. Harrison,

Filed ....., 191....

JAN 10 1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ....yrs....mos....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ....yrs....mos....ds.

(Signed) .....M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Jan. 10., 1923

20-UNDERTAKER Hitz, Robert & Elliot — ADDRESS 1725 Ashland Av.

N.B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

D71025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71025

CERTIFICATE OF DEATH.

90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 513 Hargrove alley St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Anna Smith

(Residence in Baltimore: No. 513 Hargrove alley 30 St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

6-DATE OF BIRTH. Dont Know (Month) (Day) 187? (Year)

7-AGE. 46 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION. (a) Trade, profession, or particular kind of work. House work

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Chas Gompers

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Carrie Runyan

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Perrines

(Address) 513 Hargrove Alley

15- Filed ..... 192.....

Robert P. Harrison, Burial Permit Clerk. Registrar.

JAN 9 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 7 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy or~~ Inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, autopsy or~~ Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

Dont Know (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia probably

..... (Duration) ..... yrs. mos. 2 ds.

(Signed) M K Fornachetti M. D. (Coroner.)

1-9 1923 (Address) 117 N Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Md - Cedar Lawn DATE OF BURIAL. Jan 11 1923

20-UNDERTAKER. Mrs Robert A Ellis ADDRESS 1725 Ashland Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER, WITH CARBON INK—THIS IS A PERMANENT RECORD.

D71026 HEALTH DEPARTMENT—CITY OF BALTIMORE D71026

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No. C 74-006

City of BALTIMORE: (No. 4901 Eastern Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Donahue

(Residence in Baltimore: No. 4901 Eastern Ave St.; yrs. (Abt 31) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Unknown

6-DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7-AGE, about 6 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Watchman at Edgewood Arsenal
(b) General nature of industry, business, or establishment in which employed (or employer) Gov't

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. C. Donahue

(Address) Lexington Bldg

15- Filed. 192 Robert F. Duffy Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 8th 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and Jury find that said deceased came to death (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Theo. B. Norton M. D. (Coroner)

Jan 10th 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

Accd. MD

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, Jan 12, 1923

20-UNDERTAKER, J. J. Deming & Co — ADDRESS Lexington & Liberty

AR 1 01823

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71027

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71027

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Bolton St. ST. 14 WARD)

2-FULL NAME Jannie H. Fergusson

(a) RESIDENCE. NO. 1609 Bolton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 5. 1852

7 AGE — Years: 70 — Months: 2 — Days: 4 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Armstrong Thomas 1605 Bolton St

15 Filed Jan 10 1923 Robert P. [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1922, to Jany 9, 1923, that I last saw her alive on Jany 8, 1923, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis -

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency -

(duration) — yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? None -

(Signed) Chas W. Lamar, M. D.

Jan 9. 1923 (Address) 132 Park ave -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	Jan 10 1923
20 UNDERTAKER	ADDRESS
John Mitchell	1201 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 10 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71028

CERTIFICATE OF DEATH.

90 D71028

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 E. HAMILTON AVE., HAMILTON ST., 27 WARD)

2-FULL NAME MOLLIE P. OWENS,

(a) RESIDENCE NO. 107 E. HAMILTON AVE., HAMILTON ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred LIFE yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	WIDOWED.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of FELIX OWENS

6 DATE OF BIRTH (month, day, and year) OCT. 14, 1843.

7 AGE	79 Years	2 Months	24 Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HOUSEWORK

(b) General nature of industry, business, or establishment in which employed (or employer) AT HOME

(c) Name of employer

9 BIRTHPLACE (city or town) BALTIMORE,
(State or country) MARYLAND.

PARENTS

10 NAME OF FATHER JAMES CHRISTOPHER.

11 BIRTHPLACE OF FATHER (city or town) BALTIMORE,
(State or country) MARYLAND.

12 MAIDEN NAME OF MOTHER SARAH READ.

13 BIRTHPLACE OF MOTHER (city or town) BALTIMORE,
(State or country) MARYLAND.

14 Informant SAMUEL CHRISTOPHER.
(Address) 107 E. HAMILTON AVE., HAMILTON.

15 JAN 10 1923 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN. 8th, 19 23.

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to Jan 8, 1923,
that I last saw h[illegible] alive on Jan 8, 1923
and that death occurred, on the date stated above, at 10:10 P. m.
The CAUSE OF DEATH* was as follows:

Mitral Regurgitation,

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation,
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Geary A. Jones, M. D.

Jan 9, 1923 (Address) 27 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK CEMETERY.	JAN. 11, 19 23

20 UNDERTAKER Fred K. Lassahn & Sons ADDRESS FULLERTON.

D71029

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71029

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 411 W. Biddle St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary R. Murray,

(Residence in Baltimore: No. 1005 Linden Av. St.; yrs. 49 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: about ..... (Month) ..... (Day) 1874 (Year)

7-AGE: about 49 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): Balto. Md,

PARENTS.

10-NAME OF FATHER: Louis Murray

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Rebecca Kelley

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Levi Murray

(Address) 471 George St.

15-

Filed ..... 19..... Registrar.

Robert E. Morrison,

JAN 10 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 8, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Uremic Intoxication

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) J. C. Hemmeter, M. D.
(Coroner.)

Jan. 10, 1923 (Address) 2302 Eutaw Pl.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Md Auburn Cem	1-11, 1923
20-UNDERTAKER,	ADDRESS
George H. Holland	1631 Druid Hill Ave

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D71030

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71030

CERTIFICATE OF DEATH.

181-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1134 Druid Hill Ave St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Geo. W. Baker

(Residence in Baltimore: No. 1134 Druid Hill Ave St.; yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	Single

6-DATE OF BIRTH. May 4, 1887
(Month) (Day) (Year)

7-AGE. 34 yrs. 8 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Pool Room
(b) General nature of industry, business, or establishment in which employed (or employer)..... attendant

9-BIRTHPLACE, (State or Country) Montgomery Co, Md.

PARENTS.

10-NAME OF FATHER, Henry T. Baker

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Dorsey

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alberta Baker

(Address) 1630 Bruce

15-

Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 4, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an unnecessary (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by gas

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Jan 10 1923 (Address) 720 Eutaw Bldg

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

JOHNS HOPKINS HOSPITAL 1923

20-UNDERTAKER, ADDRESS

Commissioner Health. JAN 11 1923

Per. Wm. E. WOODS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71031

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 N. Bond ST., 6 WARD)

2-FULL NAME Meyer Sandler

(a) RESIDENCE NO. 10 N. Bond ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Repairing

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Yonedel Kovna, Russia

PARENTS

10 NAME OF FATHER Solomon Sinkus

11 BIRTHPLACE OF FATHER (city or town) Yonedal (State or country) Kovna, Russia

12 MAIDEN NAME OF MOTHER Merowitz

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Kovna, Russia

14 Informant Daughter, Anna (Address) 10 N. Bond St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

JAN 10 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1923, to Jan. 10, 1923, that I last saw h[illegible] alive on Jan. 6, 1923, and that death occurred, on the date stated above, at 8 9. m.

The CAUSE OF DEATH* was as follows: Cebral Hemorrhage

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Senility, 6

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Harry Sandler, M. D.

, 19 (Address) 1x. 4 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rawsky Rep DATE OF BURIAL Jan. 11 1923

20 UNDERTAKER Jack Levis ADDRESS 1439 E. Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71032

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71032

CERTIFICATE OF DEATH.

24 90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 527 E.Gitting St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick J.O'Neill. 35 ---------- .

(Residence in Baltimore: No. 527 E.Gitting St. St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. August 5th, 1883. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
39 yrs. 5 mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boiler maker 13
(b) General nature of industry, business, or establishment in which employed (or employer): B & O R R Co.

9-BIRTHPLACE, (State or Country). Wythville Va.

PARENTS.

10-NAME OF FATHER, James O'Neill.

11-BIRTHPLACE OF FATHER, (State or Country). Wythville Va.

12-MAIDEN NAME OF MOTHER, Jane Jones.

13-BIRTHPLACE OF MOTHER, (State or Country). Wythville Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna O'Neill.(wife).

(Address) 527 E.Gitting St.

15- Robert P. Harrison, Filed JAN 10 1923 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 8th, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Jan. 9, 1923. (Address) 1017 E. Charles st.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-REMOVAL.	DATE OF BURIAL.
Mt. Carmel Cem.	1/11 1923

20-UNDERTAKER.	ADDRESS
J. Geo. McCully	130 E. Fort.

Spec.—1-10-21—M&T—1500 Blks.

Dr. Mazyck 3115 E. Balto

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71033

CERTIFICATE OF DEATH.

129 **D71033**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 S. Clinton St. ST., 26 WARD)

2-FULL NAME William Shields

(a) RESIDENCE No. Edgevale Road Brook. a A Co. Md. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 0 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Shields

6 DATE OF BIRTH (month, day, and year) Dec. 24 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Skoons
(Address) A. A. Co. Md.

15 Filed 1923 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9 1923 to Jan 9 1923.

that I last saw him alive on Jan 9 1923

and that death occurred, on the date stated above, at 119 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 1 yrs. — mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Maxwell L. Mazyck M. D.

1/10 1923 (Address) 3115 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL 1/11 1923

20 UNDERTAKER L. F. McCully

ADDRESS 130 E. Fort

1 10 1923

Spec.—1-10-21—MAT—1500 Blks.

15-9743
D71034

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 84

D71034

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Williams

(a) RESIDENCE No. 24 Landesdale Ave ST., Youngstown, Ohio WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ——yrs. ——mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: John Williams Father

6 DATE OF BIRTH (month, day, and year): Oct. ? 1916.

7 AGE: Years 6 Months 3 Days ? If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of Industry, business, or establishment in which employed (or employer): ——

(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: John Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Langene Rippy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Ca.

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Reported

15 JAN 10 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1922, to Jan 9, 1923, that I last saw him alive on Jan 9, 1923, and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Multiple Neurofibromata of Central Nervous System
(Von Recklinghausen's Disease)

(duration) 1 yr. 3 mos. 10 ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) 2 yrs. 2 mos. 3 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? Yes Date of Dec 29-1922

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Wayson L. Goldwell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Youngstown Ohio

DATE OF BURIAL: Jan 10 1923

UNDERTAKER: Mrs R. A. Ellis

ADDRESS: 1722 Eutaw

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 10 1923

Spec.—1-10-21—M&T—1500 Bks.

D71035 HEALTH DEPARTMENT—CITY OF BALTIMORE ~~D71035~~

CERTIFICATE OF DEATH. 90

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1800 N Monroe St. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Weiner

(a) RESIDENCE NO. 1800 N Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mark Weiner

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 67 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Solomon Winberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Charles B. Fox

(Address): 513 Aisquith Street

15 Filed JAN 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1921, to Jan 10, 1923,

that I last saw her alive on Jan 9, 1923,

and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary): Chr. Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A Abraham, M. D.

Jan 11, 1923 (Address) 2360 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon — DATE OF BURIAL: Jan 11 1923

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E. Balt

Spec.—1-10-21—M&T—1500 Blks.

D71036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D71036

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Marlborough Apts ST., 14 WARD)

2-FULL NAME Rosetta R. Rohr

(a) RESIDENCE NO. Marlborough Apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry J. Rohr

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE: Years 70 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Jacob Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bavaria

12 MAIDEN NAME OF MOTHER: Rosenbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bavaria

14 Informant: Daniel Stiefel

(Address): Marlborough Apts

15 Filed JAN 11 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 10 1923

17

I HEREBY CERTIFY, That I attended deceased from June 18, 1922 to Jan. 10, 1923.

that I last saw h[illegible] alive on Jan 9, 1923,

and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis 2

Arthritis deformans

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Bright's

(duration) about yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis.

(Signed) Theodore H. Matthews, M. D.

, 19 (Address) 1525 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chebra Sholam Cemetery

DATE OF BURIAL: Jan 13 1923

20 UNDERTAKER: J. Ahrens & Co

ADDRESS: 1611 Madison Ave

John Green

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71037

CERTIFICATE OF DEATH.

38 D71037

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... ST., No WARD)

2-FULL NAME John Green

(a) RESIDENCE NO. Unknown ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Lorenia Green

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE Years 46. Months ... Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Md. Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant Bay View Hospital (Address) Balto, Md.

15 Filed JAN 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 7. 1923

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922, to Jan 7. 1923

that I last saw h... alive on Jan 7. 1923

and that death occurred, on the date stated above, at 1 45 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (3 yrs Unknown)

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Senile infect

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) N. E. Edwards, M. D.

1/8, 1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 10 1923
20 UNDERTAKER	ADDRESS
Edward Ruggold	1463 Carey

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71038

101-001

D71038

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie L. Davis

(a) RESIDENCE NO. 2610 Riggs Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Davis

6 DATE OF BIRTH (month, day, and year) April 2" 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	9 --	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md. (State or country)

PARENTS

10 NAME OF FATHER Samuel Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary E. Lesson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Municipal Hospital Records. (Address)

15 JAN 11 1923 Filed ....., 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8 19 23

17 I HEREBY CERTIFY, That I attended deceased from January 1, 19 23 to January 8, 1923.

that I last saw her alive on January 7, 1923,

and that death occurred, on the date stated above, at 6:20 A. M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

1/8/19 22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Jan 11" 1923

20 UNDERTAKER Joseph L. B. Cook — ADDRESS 1003 N. Dallas St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71089

99-001

D71039

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 N Amity ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beulah Washington

(a) RESIDENCE. No. 209 N Amity ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col.	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 7th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md Baltimore

PARENTS

10 NAME OF FATHER Andrew Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Beula Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Fannie Washington

(Address) 209 N Amity St

15 Filed JAN 11 1923 19.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1923, to Jan 9, 1923, that I last saw h.... alive on Jan 5, 1923, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

I Bronchitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) F Norwood, M. D.

Jan 11th, 19.... (Address) 1317 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	Jan 11th 1923

20 UNDERTAKER	ADDRESS
A. Jones	111 S. Calhoun St

INSTRUCTIONS—TYPEWRITER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71040

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

187-007 D71040

Registered No. C.....

City of BALTIMORE: (No. Mercy Hospital St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John W. Demuth

(Residence in Baltimore: No. 316 S. Calhoun St.; 10 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Dec 23 Don't Know 1876
(Month) (Day) (Year)

7-AGE. 47 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Machinist
(b) General nature of industry, business, or establishment in which employed (or employer). 031

9-BIRTHPLACE, (State or Country). Pa.

PARENTS.

10-NAME OF FATHER. Lewis Demuth

11-BIRTHPLACE OF FATHER, (State or Country). Pa.

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country). Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Smith

(Address) 316 S. Calhoun st

15-

Filed JAN 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan 9 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy~~ or Inquiry.) thereon and from the evidence obtained by said ~~Inquest, au-~~ topsy or Inquiry.) find that said deceased came to ~~h~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Liver

(Duration) ..... yrs. 4 hours mos. ..... ds.

CONTRIBUTORY (Secondary) Cause of Injuries Carpenters + Wall at M. Glen shops

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Jarrold M. D.
(Coroner.)

1-11 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park	Jan 13th 1923
20-UNDERTAKER.	ADDRESS.
A. Jones	111 S. Gilmor st

Spec.—1-10-21—M&T—1500 Bks.

Fenby
1223 N Carolina

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71041 129 D71041

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE. (No. 1103 - E. Federal St., 9 WARD)

2-FULL NAME Cecelia M- Aro

(a) RESIDENCE No. 1103 - E. Federal ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2-1846

7 AGE Years 76 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph A. Aro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Catherine A. Aro
(Address) 1103 E. Federal.

15 Filed JAN 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 - 1923

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1923, to Jan. 10, 1923.

that I last saw her alive on Jan. 9, 1923.

and that death occurred, on the date stated above, at 1115 a m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary tests

(Signed) Edwin B. Fenby, M. D.

1/11/1923 (Address) 1223 N. Carolina st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 1/12 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Wenry

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71042

CERTIFICATE OF DEATH.

60-001 D71042

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. John St. & Lafayette Ave. St., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Lillian Wenry

(a) RESIDENCE NO. 111 Mc Mechen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July ? 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
25 years				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manicurist

(b) General nature of industry, business, or establishment in which employed (or employer) Citizens Barber Shop St. Paul St.

(c) Name of employer Mr. Hartman

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. E. D. Clark

(Address) 111 Mc Mechen St.

15 Filed JAN 11 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923, to Jan 9, 1923, that I last saw h er alive on Jan 9, 1923, and that death occurred, on the date stated above, at 1:49 p m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart

Toxic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exophthalmic goitre

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 9, 1923

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Norman E. Tannenbaum, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 1/12 1923

20 UNDERTAKER Wm Cook

ADDRESS 602 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 **D71043**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 609 W Barre St. 21 WARD)

2-FULL NAME Nicholas Robey

(a) RESIDENCE NO. 609 W. Barre St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of: Elizabeth Robey

6 DATE OF BIRTH (month, day, and year): Aug. 2, 1852

7 AGE: Years 71. Months 5. Days 6. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): Hauling

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Nelson Robey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ann Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Eliz. Robey (Address) 609 W. Barre St

15 Filed JAN 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 9 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28 1923 to Jan 9 1923

that I last saw alive on Jan 9 1923

and that death occurred, on the date stated above, at 8 pm.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Cardiac Hypertrophy

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Chr Interstitial Nephr

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M G Fuhrmeyer, M. D.

Jan 10 '23 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan 12 1923

20 UNDERTAKER: Wm. Cook — ADDRESS: 502 E. North Ave

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71044

CERTIFICATE OF DEATH.

129 D71044

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 Baltimore Ave ST., 16 WARD) St Helena Md

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Waterman Kelly

(a) RESIDENCE NO. 303 Baltimore Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie E Kelly

6 DATE OF BIRTH (month, day, and year) June 2 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	42	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paint Bethelhem

(b) General nature of industry, business, or establishment in which employed (or employer) Steel Co. Md 150

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Maryland

PARENTS

10 NAME OF FATHER Thomas H Kelly

11 BIRTHPLACE OF FATHER (city or town) Dont Know (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Christmas

13 BIRTHPLACE OF MOTHER (city or town) Dont Know (State or country) Maryland

14 Informant Mrs Bessie E Kelly (Address) 303 Baltimore Ave St Helena Md

15 Rec'd JAN 11 1923 ROBERT R. KRAUTH, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 30, 1922, to Jan 6, 1923, that I last saw h alive on Jan 6, 1923, and that death occurred, on the date stated above, at 1145 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemic Poisoning

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albumen

(Signed) Frank A. Ellard, M. D.

1-10 1923 (Address) Spencer Bldg Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Jan 11 1923

20 UNDERTAKER John F Denny — ADDRESS, 713 Light St

Spec.—1-10-21—M&T—1500 Bks.

D71045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002 **D71045**

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Anthony ST. 10 WARD)

2-FULL NAME Robert. A. Redmond.

(a) RESIDENCE NO. 1414 Anthony St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Redmond

6 DATE OF BIRTH (month, day and year): 6/23/1841

7 AGE: Years 81 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Poultry

(b) General nature of industry, business, or establishment in which employed (or employer): Dealer

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Robert Redman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Redmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Robert A. Redman.

(Address) 1414 Anthony St.

15 Filed JAN 11 1923

ROBERT R. TRAUTH, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 20th, 19 23 to Jany 9th 19 23.

that I last saw him alive on Dec 26th, 19 23

and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. F. Lowe, M. D.

Jan 6, 19 23 (Address) 1501 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery. DATE OF BURIAL: Jan. 12 1923

20 UNDERTAKER: Geo. J. Ruth ADDRESS 1735 Harford Ave.

Spec.—1-10-21—M&T—1500 Blks.

D71046 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D71046

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Cummings

(a) RESIDENCE NO. 100 N. Front st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Cody

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records

(Address) M.T.H.

15 FILED JAN 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 6. 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1922, to Jan. 6, 1923,

that I last saw him alive on Jan. 6, 1923,

and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Clyde Kinnel, M. D.

1-7-23 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Heath Cemetery

DATE OF BURIAL 1/11 1923

20 UNDERTAKER Thos M. Fink

ADDRESS 1737 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71047

CERTIFICATE OF DEATH.

100-001

D71047

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1341 N. Fulton ave ST. 15 WARD)

2-FULL NAME Wm. Atkins

(a) RESIDENCE. NO. 1341 N. Fulton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 26 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nan

6 DATE OF BIRTH (month, day, and year): Oct. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	Two years 3			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nan

(b) General nature of industry, business, or establishment in which employed (or employer): Nan

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: William Atkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Mrs Mary Griffin
(Address) 1341 N. Fulton Ave.

15 JAN 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to Jan 10, 1923, that I last saw him alive on Jan 9, 1923, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Cardiac Paresis.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of none

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas A Fetterhoff M. D.

, 19 (Address) 1807 N North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patrick Cemetery

DATE OF BURIAL: January 19 19

20 UNDERTAKER: Mr - Mrs Pinto

ADDRESS: 1731 Bratt St

Spec.—1-10-21—M&T—1500 Bks.

D71048

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D71048

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 132 N Carlton ST. 18 WARD)

2-FULL NAME Phillip Barnett

(a) RESIDENCE NO. 132 N Carlton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 8, 1922

7 AGE — Years: — Months: 3 Days: 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Phillip Barnett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Edna Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Middleburg Va

14 Informant: Edna Carter

(Address): Balto 132 N Carlton St

15 FILED JAN 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1922, to Jany 9, 1923, that I last saw h[illegible] alive on Jany 8, 1923, and that death occurred, on the date stated above, 3.30 a m.

The CAUSE OF DEATH* was as follows:

Acute Catarrhal Bronchitis

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Catarrhal Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. Bowles M. D.

1923 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Jan 11 1923

20 UNDERTAKER: Geo H Toddrin — ADDRESS: 142 White St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71049

CERTIFICATE OF DEATH.

31

D71049

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1326 North Fremont ST., 15 WARD)

2-FULL NAME Theodore Boblitz

(a) RESIDENCE NO. 1326 North Fremont ST., WARD

(Usual place of abode) about

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 10-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer in Fish Market

(b) General nature of industry, business, or establishment in which employed (or employer) Fish Cleaner

(c) Name of employer Ferdinand Kuhl

9 BIRTHPLACE (city or town) Paulton (State or country) Maryland

PARENTS

10 NAME OF FATHER George Boblitz

11 BIRTHPLACE OF FATHER (city or town) Paulton (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriett Stiffler

13 BIRTHPLACE OF MOTHER (city or town) Paulton (State or country) Maryland

14 Informant (Name) Mrs Ferdinand Kuhl (Address) 1326 N Fremont ave

15 JAN 11 1923 Filed . 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 13 1922 to Jan 9 1923, that I last saw him alive on Jan 9 1923, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Hemorrhage of Lung

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Fry, M. D.

1/10, 1923 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	1/11/23 19

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson Ave

N. B.—WRITE PLAINLY, with ordinary pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D71050

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D71050

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2316 E. Oliver ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Kollmer

(a) RESIDENCE NO. 2316 E Olivier ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Kollmer

6 DATE OF BIRTH (month, day, and year): Mar 20-79

7 AGE — Years: 43 — Months: 9 — Days: 30 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sheet Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: E. Floyd Mitchell

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Jacob Kollmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Minnie Kollmer

(Address): 2316 E Oliver St

15 JAN 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1922 to Jan 10, 1923

that I last saw him alive on Jan 9, 1923

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? finding

(Signed) Fred Burgdorf M. D.

1-11-23 (Address) 60 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: 1/12 1923

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71051

CERTIFICATE OF DEATH.

D71051

REGISTERED NO. 37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 935 Leadenhall ST. 23 WARD)

2-FULL NAME Georgia Dudley

(a) RESIDENCE. No. 935 Leadenhall ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Martin Dudley

6 DATE OF BIRTH (month, day, and year) April 7th 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35 years	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Athens Tenn.

PARENTS

10 NAME OF FATHER Spotwood Rider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Athens Tenn.

12 MAIDEN NAME OF MOTHER Emma Cardden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Athens Tenn.

14 Informant Martin Dudley (Address) 935 Leadenhall St.

15 Filed JAN 11 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 8th 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15th, 1923, to Jan. 8th, 1923, that I last saw h[illegible] alive on Jan. 8th, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ——

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) J. L. Shelton, M. D.

1/9, 1923 (Address) 330 W. Hamburg St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Jan 12 1923

20 UNDERTAKER J L Brown and Son

ADDRESS 1084 Monty

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71052

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71052

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 417 N. Edw St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Emma Sailor

(Residence in Baltimore: No. 417 N. Edw St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

6-DATE OF BIRTH. January 5, 1860
(Month) (Day) (Year)

7-AGE. 63 yrs. 0 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country). unknown

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Thompson

(Address) 410 Bonaparte St

15- JAN 11 1923

ROBERT R. KRAUTER, Burial Permit Clerk
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. January 9, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes

Probably Pneumonia

(Duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) J. L. T. Collins M. D.
(Coroner)

1-10 1923 (Address) 506 E. Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Evergreen Cem.	Jan. 12 1923

20-UNDERTAKER.	ADDRESS
Mrs J. G. Locks	1302 Jefferson St

Baggett

D71053

HEALTH DEPARTMENT, CITY OF BALTIMORE

188-001

D71053

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hosp on way to Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Clara V. Baggett

(Residence in Baltimore: No. Monument Balto Co Md St.; yrs., few mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Oct (Month) 27 (Day) 1897 (Year)

7-AGE. 25 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Chas McClelland

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Margarte Sullivan

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John V. Baggett

(Address) Alberton Md.

15-

Filed. JAN 11 1923 192

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 8 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Skull & internal Injuries

(Duration) a few minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) Struck by Bt O train

(Duration) a few minutes yrs. mos. ds.

(Signed) H K Gorsuch M. D. (Coroner)

1-11 1923 (Address) 117 W Lexington St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. Prestle Dale Cem

DATE OF BURIAL. Jan 11 1923

20-UNDERTAKER. Easton Sons

ADDRESS Ellicott City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Baggett

D71054

HEALTH DEPARTMENT—CITY OF BALTIMORE

4 + 188-001

D71054

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Hilda Baggett

(Residence in Baltimore: No. Monumental Bath Co Md St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. May (Month) 27 (Day) 1921 (Year)

7-AGE. 1 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. John Baggett

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Clara Williams

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Baggett

(Address) Albemarle Road

15 JAN 11 1923 Filed 192

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 8 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock & loss of Blood & Amputation of leg & arm

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Struck by B & O R.R. Train & fatally hurt

(Duration) yrs. mos. ds.

(Signed) H. B. [illegible] M. D. (Coroner.)

1-11 1923 (Address) 1727 W. Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Thistle M E Cem

DATE OF BURIAL. Jan 11 1923

20-UNDERTAKER Easton Sons

ADDRESS Ellicott City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71055

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

D71055

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308 S. Clinton ST., No WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stilda Gronberg.

(a) RESIDENCE NO. 308 S. Clinton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) June 24-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
		6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Ernst Gronberg.

11 BIRTHPLACE OF FATHER (city or town) Sweden

(State or country)

12 MAIDEN NAME OF MOTHER Anna Hornes

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Ernst Gronberg.

(Address) 308 S. Clinton St.

15 Filed JAN 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 9, 1923, that I last saw her alive on Jan 8, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. mos 10 ds.

CONTRIBUTORY .....

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Taylor M. D.

1/13, 1923 (Address) 34 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem

DATE OF BURIAL Jan 11 1923

20 UNDERTAKER Tilly and Zeiler

ADDRESS 403 S. Wolfe St

N. B. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

D71056

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X113

D71056

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 274 S. Robinson ST., 1 WARD)

2-FULL NAME Herbert Eautair Hutson.

(a) RESIDENCE NO. 274 S. Robinson ST., 1 WARD Columbia S. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Columbia S. C.

PARENTS

10 NAME OF FATHER Herbert E. Hutson

11 BIRTHPLACE OF FATHER (city or town) S. C.
(State or country)

12 MAIDEN NAME OF MOTHER Martha Hopkins

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Martha Hutson (Mother)
(Address) 274 S Robinson St.

15 JAN 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923, to Jan 9, 1923, that I last saw him alive on Jan 9, 1923 and that death occurred, on the date stated above, at 4/10 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 30 15 Clinton

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: Jan 11th 1923

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71057

CERTIFICATE OF DEATH.

11-001

D71057

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Fremont ST., 14 WARD)

2-FULL NAME Lydia Lewis

(a) RESIDENCE NO. 1307 Fremont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: John Lewis

6 DATE OF BIRTH (month, day, and year): Not known

7 AGE: Years: Not known about 60; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Prince George Co Md

PARENTS

10 NAME OF FATHER: Nathaniel Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Caroline Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Fanna Brooks (Address) 1307 Fremont Ave

15 Filed: JAN 11 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 6, 1923, to Jan 8, 1923,

that I last saw h[illegible] alive on Jan 8, 1923,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

In Grippe

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Fly, M. D.

1/10. 1923 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn. DATE OF BURIAL: Jan 11 1923

20 UNDERTAKER: James H. Dennis ADDRESS 1303 Druid Hill Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D71058

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 520 St Paul St. (WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Lankford

(a) RESIDENCE. NO. Crisfield Md ST., WARD. Crisfield Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm A Lankford

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 65 About | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Isaac Coffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Etta M Lankford

(Address) 520 St Paul St

15 Filed JAN 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1923 to Jan 10 1923

that I last saw h alive on Jan 9 1923

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (South)

(duration) — yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H L Packard M. D.

19 (Address) 610 Aisquith

Jan 10 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Berlin Md

DATE OF BURIAL Jan 11 1923

20 UNDERTAKER Wm J Fechine

ADDRESS Norfolk Va

matters should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 71059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C. D 71059

1-PLACE OF DEATH Pommond and St

City of BALTIMORE: (No. St Joseph Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice G Saunders

(Residence in Baltimore: No. 2106 E Monument St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. January 1 (Month) (Day) 1877 (Year)

7-AGE. 46 yrs. mos. 8 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). At Home

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS

10-NAME OF FATHER. Wm Gibbs

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mrs Kramm

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos W Saunders

(Address) 2106 E Monument St

15-

FILED JAN 11 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 9 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Automobile accident - Struck by
Fractured Skull
Cerebral Hemorrhage
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. H. Collins M. D.
(Coroner.)

1-11-1923 (Address) 508 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery DATE OF BURIAL. Jan 13 1923

20-UNDERTAKER. Kenny Hoecke & Co ADDRESS 1301 E Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

Buckler

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71060

CERTIFICATE OF DEATH.

161-001 D71060

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3745 Monday ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Victor Buckler

(a) RESIDENCE NO. 3745 Monday ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
		1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Frank Buckler

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Corcoran

13 BIRTHPLACE OF MOTHER (city or town) Thomastown (State or country) Ireland

14 Informant Frank Buckler

(Address) 3745 Monday Ave

15 JAN 11 1923 ROBERT R. KRAUSER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1922, to Jan 10, 1923, that I last saw h[illegible]ive on Jan 10, 1923, and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 1 mos 6 ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James L. Kemp M. D.

11/11, 1923 (Address) 1729 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	1/16 19 23

20 UNDERTAKER W. J. Tschiand Son Pennsylvania Ave

ADDRESS

N. B.—WHITE PAPER, WITH CARBON SET, FURNISHED FREE. Every question on this form should be carefully answered. If the information is not known, or is not applicable, the fact should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

D71061

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71061

185

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hosp.

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Byrne

(a) RESIDENCE No. 1528 McCulloh St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 84 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Nov. 17, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) County Wicklow
(State or country) Ireland

PARENTS

10 NAME OF FATHER Edward Byrne

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Doyle

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Miss Bessie Byrne
(Address) 1528 McCulloh Street

15 Filed JAN 1 1923, 19 ROBERT R. KNAUER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1922, to Jan 10, 1923, that I last saw h[illegible] alive on Jan 10, 1923, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Secondary Pneumonia

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death? Premises.

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) S. McKinney, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	1/13 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH INK. CONSULT INSTRUCTIONS FOR THIS CERTIFICATE. PHYSICIANS should be careful in giving information. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71062

CERTIFICATE OF DEATH.

10 D71062

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 N. Ellwood Ave St.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Fortenbaugh

(Residence in Baltimore: No. 110 N Ellwood Ave, St.: ....yrs. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F.	W.	S

6-DATE OF BIRTH, Dec. 25 (Month) 1915 (Day), 1 (Year)

7-AGE, ...yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Joseph A. Fortenbaugh

11-BIRTHPLACE OF FATHER (State or Country), Baltimore City

12-MAIDEN NAME OF MOTHER Emma E Hartman

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. Fortenbaugh

(Address) 110 N. Ellwood Ave.

15-

Filed JAN 7 1923 191... [illegible] Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1/6/23 (Month) (Day) 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/10/23 191..., to 1/11/23 191..., that I saw h[illegible] alive on 1/10/23 191..., and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar Left Thorax

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(Duration) ....yrs. ....mos. 1 ds.

(Signed) F. D. Hartman M. D.

1/11/23, 191... (Address) 2919 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Jan. 12, 1923

20-UNDERTAKER Harry Stocksdale ADDRESS 1301 E Eager St

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D71063

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D71063

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 N. Rutland Ave ST. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Gans

(a) RESIDENCE NO. 1618 N. Rutland Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if of foreign birth? 72 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Herman Gans

6 DATE OF BIRTH (month, day, and year) May. 15th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Frederick Ickert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mr. Henry P. Gans

(Address) 1618 N. Rutland Ave

15 Filed JAN 11 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1923, to Jan 9, 1923,

that I last saw h— alive on Jan 9, 1923,

and that death occurred, on the date stated above, at 11 40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis - Arteriosclerosis

Hypertension (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas B Lemmon M. D.

1/10, 1923 (Address) 718 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Jan. 15 1923

20 UNDERTAKER Henry Hock Lord — ADDRESS 1301 E Eager St

N.B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71064 HEALTH DEPARTMENT—CITY OF BALTIMORE D71064

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 W. Mulberry ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy L. Leland

(a) RESIDENCE. NO. 1209 W. Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Clara M. Leland

6 DATE OF BIRTH (month, day, and year) July 26 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer) Sporting Goods

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Co.
(State or country) Virginia

PARENTS

10 NAME OF FATHER John W. Leland

11 BIRTHPLACE OF FATHER (city or town) Lancaster Co.
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth F. R. Lee

13 BIRTHPLACE OF MOTHER (city or town) Lancaster Co.
(State or country) Virginia

14 Informant Clara M. Leland
(Address) 1209 W. Mulberry St.

15 Filed JAN 11 1923, 19 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923, to Jan 9, 1923, that I last saw h[illegible] alive on Jan 8, 1923, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy F. Phillips, M. D.

Jan 11, 1923 (Address) 1929 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Jan 11 1923

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North Ave

Spec.—1-10-21—M&T—1500 Bks.

Bauer

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71065

REGISTERED NO. D71065

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2127 N Baltimore ST., 20 WARD)

2-FULL NAME Sarah Muhly.

(a) RESIDENCE NO. 2127 N Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 11 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Male~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Muhly.

6 DATE OF BIRTH (month, day, and year) Jan. 17 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo. L. Bauer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Emma M. Blessing.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Geo. E. Muhly.
(Address) 2115 St. Charles St

15 Filed JAN 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1922, to Jan. 10, 1923, that I last saw h 2 alive on Jan. 10, 1923, and that death occurred, on the date stated above, at 5 40 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope

(duration) 24 hrs. yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual.

(Signed) G. Lehrke Ewalt, M. D.

1/10, 1923 (Address) 905 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emanuel - (Germantown) DATE OF BURIAL 1-12 1923

20 UNDERTAKER Mrs Chas A Rohde ADDRESS 100 N Arlington Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71066

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 410 N. Hoffman ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Reid

(a) RESIDENCE NO. 410 N. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1562

7 AGE: 61 (Years / Months / Days)

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Wm. Porter

(Address) 410 N. Hoffman St.

15 Filed JAN 11 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/10/1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1922 to Jan. 10, 1923.

that I last saw h. W alive on Jan 8, 1923,

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Uremia (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 6 mos. 4 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John A. Fontaine, M. D.

1/10, 1923 (Address) 1019 Dulaney Valley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D. C.

DATE OF BURIAL: Jan 12 1923

20 UNDERTAKER: Daniel Easton

ADDRESS 716 Park

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71067 D71067

CERTIFICATE OF DEATH.

+ 100-001

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., 4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Tucker

(a) RESIDENCE NO. Cockeysville, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
M	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) N.D.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Maryland

PARENTS

10 NAME OF FATHER Jno Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lizzie Jacks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Univ Hospital records

15 JAN 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/13, 1922, to 1/10, 1923,

that I last saw him alive on Jan. 10, 1923,

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Benign hypertrophy of prostate gland

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home (?)

Did an operation precede death? yes Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W Forrester, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Hill Balto Co Md DATE OF BURIAL Jan 11 1923

20 UNDERTAKER A S Marshall ADDRESS 3539 Fall Road

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71068

CERTIFICATE OF DEATH.

101-00

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2904 Hilldale ave ST.; 16 WARD)

2-FULL NAME Charles Perry Stewart

(a) RESIDENCE. No. 2904 Hilldale ave ST.; WARD. 16

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary T. Stewart

6 DATE OF BIRTH (month, day, and year): Sept 26, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Night watchman

(b) General nature of industry, business, or establishment in which employed (or employer): 062

(c) Name of employer: Bethlehem Steel Co. (Dk H Bridge)

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: John M. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Louise Perry

13. BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Edwin J. Stewart

(Address): 2904 Hilldale Ave.

15 Filed: Robert P. Harrison, Registrar

Burial Permit Clerk.

N 111923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923 to Jan 9, 1923

that I last saw h.im alive on Jan 9, 1923

and that death occurred, on the date stated above, at 10 55 A.m.

The CAUSE OF DEATH* was as follows:

acute Lobar Pneumonia

Bronchitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald L. Tonry M. D.

, 19 (Address) 414 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Govans

DATE OF BURIAL: 1/12 1923

20 UNDERTAKER: E. A. Weidefeld

ADDRESS: 601 E 22nd St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71069

D71069

CERTIFICATE OF DEATH.

15-99-006

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3706 Park Heights ST.; 15 WARD)

2-FULL NAME Vincent Cicero

(a) RESIDENCE. NO. 3706 Park Heights ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosaria Cicero

6 DATE OF BIRTH (month, day, and year) Sept 14 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 088

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Frank Cicero

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Bianco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Joseph Cicero 729 Hanover st

15 Filed Jan 11 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 10, 1923, that I last saw h[illegible] alive on Jan 6 1923, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) For years ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. J. Wentz, M. D.

Jan 11, 1923 (Address) 1714 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Jan 12 1923
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71070

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71070

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE — (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. ..... St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH ....., ... (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-

Filed ....., 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH ....., ..., 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

....., 191.... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner Health.
Per. Wm. S. WOODALL
JAN 11 1923

Robert P. Harrison, Registrar.

JAN 11 1923

Burial Permit Clerk.

0035

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should supply CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71071 D71071

CERTIFICATE OF DEATH.

X 49

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 Park Ave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mark R. Robertson.

(Residence in Baltimore: No. 1022 Park ave. St.; ...yrs., 7 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	married

6-DATE OF BIRTH. ..... Dont know ....., 1870
(Month) (Day) (Year)

7-AGE 52 yrs. dont know mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Minister
(b) General nature of industry, business, or establishment in which employed (or employer) ..... A.M.E. Church

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, William Robertson

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER dont know

13-BIRTHPLACE OF MOTHER (State or Country), dont know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nina Brooks Robertson

(Address) 1022 Park Avenue

15- Robert P. Harrison, 191.....
Burial Permit Clerk, Registrar.

N 1 14823

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 10, 1913.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 20 1912, to Jan. 10 1913, that I saw him alive on Jan. 8 1913, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Prostate Gland. Metastases in Pelvis & Spine.

(Duration) ...yrs. 9 mos. ...ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ...yrs. ...mos. ...ds.

(Signed) ..... M. D.

Jan 10 1913, 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Hagerstown Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	January 12 191. 3

20-UNDERTAKER JOHN A BISHOP & SON W. Thomas Bishop

ADDRESS 1107 Druid Hill Avenue

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71072

160 D71072

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 E. Lindall St. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Bruce Marshall

(a) RESIDENCE NO. 401 E. Lindall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 4, 1917

7 AGE — Years: — Months: 7 Days: 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Samuel C. Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Annie Schellhase

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Samuel C. Marshall (Address): 401 E. Lindall St.

15 Filed: N 11923 Registrar: Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7. 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Jan 7, 1923, that I last saw h[illegible] alive on Jan 7, 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

Mal-Nutrition

(duration) yrs. 1 mos 9 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem.

DATE OF BURIAL: Jan. 17 1923

20 UNDERTAKER: [illegible]

ADDRESS: [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71073

D71073

CERTIFICATE OF DEATH.

× 131

1-PLACE OF DEATH FORT MCHENRY, BALTIMORE, MD.

REGISTERED NO.

CITY OF BALTIMORE: (No. U.S. VETERANS' HOSPITAL, 56 ST., 124 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME WOOD, Wilson

(a) RESIDENCE No. Welch, W.Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	28	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 059

(b) General nature of industry, business, or establishment in which employed (or employer) Plumbing

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Welch, W.Va.

PARENTS

10 NAME OF FATHER --

11 BIRTHPLACE OF FATHER (city or town) -- (State or country) --

12 MAIDEN NAME OF MOTHER --

13 BIRTHPLACE OF MOTHER (city or town) -- (State or country) --

14 Informant (Address) Hospital Records, Fort McHenry, Md.

15 JAN 11 1923 Robert [illegible] Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from November 4, 1920, to January 10, 1923, that I last saw him alive on January 10, 1923, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation, acute

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pyelonephritis, left

(duration) 5 yrs. 9 mos. - ds.

18 Where was disease contracted if not at place of death? Welch, W.Va.

Did an operation precede death? Yes Date of Jan. 9, 1923.

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis & operation

(Signed) [signature] Surgeon (R) M. D.

1/11 1923. (Address) Fort McHenry, Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Welch W. Va. DATE OF BURIAL 1/11 1923

20 UNDERTAKER S. Guinan & Bro ADDRESS 1127 E Balto St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71074

D71074

CERTIFICATE OF DEATH.

+ 129

1-PLACE OF DEATH -U.S. Veterans' Hospital # 56, Baltimore, Md.

CITY OF BALTIMORE: (NO. ..... ST., 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CECIL E. WARDELL

(a) RESIDENCE NO. ..... Elkton, Maryland. ..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	26	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) ..... (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant ..... (Address) Hospital Records Fort Mc Henry, Md.

15 Robert P. [illegible], .19 ..... Registrar

N 1 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, .19 22 . to January 10, .1923 .

that I last saw him alive on January 10, .1923.

and that death occurred, on the date stated above, at 3.10 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic, interstitial, advanced

Unknown (duration) yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uremia chronic

Unknown (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical History

(Signed) H. H. Lee Surgeon (R) ....., M. D.

1/11, 19 23 (Address) Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton Md

20 UNDERTAKER J. Lennon & Bro

DATE OF BURIAL 1/11 1923

ADDRESS 1127 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D71075

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71075

74-001

D71075

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 703 Scott ST., 21 WARD)

2-FULL NAME Harry C. Flynn

(a) RESIDENCE NO. 703 Scott ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. ✓ mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan 2—1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) city

PARENTS

10 NAME OF FATHER James Flynn

11 BIRTHPLACE OF FATHER (city or town) (State or country) city

12 MAIDEN NAME OF MOTHER Mima Farran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) city

14 Informant James Flynn

(Address) 703 Scott St

JAN 11 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1923, to Jan 9th, 1923, that I last saw h— alive on Jan 9th, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edw Gundlach, M. D.

Jan 10, 1923 (Address) 517 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL Jan 12 1923

20 UNDERTAKER W. J. Gilmartin Sons ADDRESS Walbrook

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 11 1923

Spec.—1-10-21—M&T—1500 Blks.

(Burdell)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71076

CERTIFICATE OF DEATH.

129 D71076

REGISTERED NO.

1-PLACE OF DEATH Bozman Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 2 WARD)

2-FULL NAME Mary Burdell 812 S. Stricker St.

(a) RESIDENCE NO. 220 S. Ann St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Burdell

6 DATE OF BIRTH (month, day, and year) 6/15/1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Hospital Records)

(Address)

15 Filed ....., 19 ..... Registrar

Robert P. Garrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/10/23 19

17 I HEREBY CERTIFY, That I attended deceased from 1/8/23, 19 ..... to 1/10/23, 19 ..... ●

that I last saw her alive on 1/10/23, 19 .....

and that death occurred, on the date stated above, at 12 30 p m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ..... yrs. 1 week mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. McCrea, M. D.

, 19 (Address) Bozman Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem. DATE OF BURIAL 1/12/23

20 UNDERTAKER George J. Ruth ADDRESS 1035 Hayward

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

JAN 11 1923

Spec.—1-10-21—M&T—1500 Bks.

(Williams) ✓

D71077

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71077

CERTIFICATE OF DEATH

38

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Clayton G. Williams

(a) RESIDENCE NO. 18 Mottet Ct ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Unk yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland Baltimore

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do.

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant Bay View Hospital (Address) Balto (Md)

15 Robert F. Harrison, Filed ....., 19..... Registrar

1 11 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1922 to Jan 10, 1923

that I last saw h alive on Jan 10 1923

and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Terminal Bronchio-Pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) General Paralysis

Tuberculosis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unk

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) H. Goldowsky Interne M. D.

1/11 1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem. Melvale — DATE OF BURIAL Jan 12, 1923

20 UNDERTAKER E. LeRoy Stiffler — ADDRESS 125 E Northern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71078

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71078

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 Poplar Grove ST.; 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Loechel

(a) RESIDENCE. NO. 2004 Poplar Grove ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise M. Loechel

6 DATE OF BIRTH (month, day, and year) Oct 9 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor 080

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fred. L. Loechel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Frederick L. Loechel

(Address) 2004 Poplar Grove

15 Filed Robert P. Garrison, Registrar

Burial Permit Clerk.

11 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 29, 19 19, to Jan 10, 1923,

that I last saw h~~im~~ alive on Jan 9, 1923,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about (duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. C. Conser, M. D.

1-10, 1923 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudoun Park Cem	Jan 13, 1923
20 UNDERTAKER E. LeRoy Stifflet	ADDRESS 1038 E North

Spec.—8-24-14—M. & T.—2000 Bks.

Joseph Fuka ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71079

CERTIFICATE OF DEATH.

90 D71079

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 N. Madeira ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Fuka

(Residence in Baltimore: No. 908 N. Madeira St.; 2 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, November (Month) 1 (Day) ..... (Year)

7-AGE, 74 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Joseph Fuka

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Fuka

(Address) 908 N. Madeira St.

15- Filed JAN 11 1923, 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 9 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1912, to Jan 9 1923, that I saw h[illegible] alive on Jan 9 1923, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH was as follows:

Uterine Regurgitation

(Duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Complication

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred Lawrence M. D.

1-11, 191 23 (Address) 806 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Jan 13, 1923

20-UNDERTAKER Grant Croxton — ADDRESS 1916 Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71080 HEALTH DEPARTMENT—CITY OF BALTIMORE 10 D71080

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST.; 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Cosky

(a) RESIDENCE. No. 1208 N. Bradford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): May 24-1921

7 AGE: Years 1; Months 8; Days 18; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: James W Cosky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto md.

12 MAIDEN NAME OF MOTHER: India Mass

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto md

14 Informant (Address): James W. Cosky 208 N. Bradford St

15 FILED JAN 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to Jan 11, 1923, that I last saw him alive on Jan 11, 1923, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal, nasal + pharyngeal.

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) Blackman, M. D.

1/12/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakton Hill Cem — DATE OF BURIAL: 1/12/23

20 UNDERTAKER: Henry Lutz — ADDRESS: 1203 N Broadway

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71081

CERTIFICATE OF DEATH.

74-001

D71081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 W Cross ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Banks

(a) RESIDENCE NO. 1419 W. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mch 1859

7 AGE: Years 64; Months —; Days —; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Sylvia Bird

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Sarah Williams

(Address) 419 W Cross St

15 JAN 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1922, to Jan 10, 1923

that I last saw her alive on Jan 9, 1923

and that death occurred, on the date stated above, at 9 40 A. m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) D Obscure

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. W. Horn M. D.

Jan 11, 1923 (Address) 712 S Mansfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Reeds Wby. Northumberland Co. Va

DATE OF BURIAL: Jan 14 1923

20 UNDERTAKER: John H. Goodwin

ADDRESS 142 Haskell St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71082

CERTIFICATE OF DEATH.

90 D71082

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 552 W. Lanvale ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward L. Cotton

(a) RESIDENCE. No. 552 W Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore & Florida Steamship Co

9 BIRTHPLACE (city or town) (State or country) Calvert Co Maryland.

PARENTS

10 NAME OF FATHER Stansbury Cotton

11 BIRTHPLACE OF FATHER (city or town) Calvert (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Miss Hatty

13 BIRTHPLACE OF MOTHER (city or town) Calvert (State or country) Maryland.

14 Informant John M. Cotton (Address) 552 W. Lanvale St.

15 Filed , 19 ROBERT R. KRAUTER, Registrar

JAN 12 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 25 -, 1922, to January 9, 1923, that I last saw h alive on January 9, 1923, and that death occurred, on the date stated above, at 7-35 m.

The CAUSE OF DEATH* was as follows:

Organic Cardiac Disease (Valvular) And Arteric Sclerosis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No Why no autopsy? Unnecessary

What test confirmed diagnosis? Clinical Symptoms

(Signed) Russell Fraser, M. D.

, 19 (Address) 746 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Jan 12 1923
20 UNDERTAKER	ADDRESS 142
Jno. H. Toadvine	W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

16-523 D71083

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D71083

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) JOHNS HOPKINS HOSPITAL ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Mason

(a) RESIDENCE NO. 152 Milligan St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred with mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Jan 4-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	1	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jas. Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Bernice Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 JAN 12 1923 ROBERT A. KNUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10-1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to Jan 10, 1923, that I last saw him alive on Jan 10, 1923, and that death occurred, on the date stated above, at 7a. m.

The CAUSE OF DEATH* was as follows:

Acute primary pneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Veech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Jan 12 1923

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71084

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D71084

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1210 St Jmmes St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Infant Chambers

(Residence in Baltimore: No. 1210 St James St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: January (Month) 6 (Day) 1923 (Year)

7-AGE: .....yrs. .....mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Harry Chambers

11-BIRTHPLACE OF FATHER, (State or Country): North Carolina

12-MAIDEN NAME OF MOTHER: Flora Torres

13-BIRTHPLACE OF MOTHER, (State or Country): N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Torres Chambers

(Address) 1210 St James St

15- Filed JAN 12 1923 192.... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: January (Month) 10 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inanition : Congenital

heart & stomach malation

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) J. S. N. Collins M. D.
(Coroner)

1-11 1923 (Address) 1.0.8 E North ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Bert cemetery — DATE OF BURIAL: Jan 12 1923

20-UNDERTAKER: Edward Bryan — ADDRESS 1631 Orleans St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D71085

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D71085

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1100 Warner St. St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna A. Reinecke.

(Residence in Baltimore: No. 1100 Warner St. St.; yrs. 34 --- mos. 9 --- ds. 10)

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: White.

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH, March 30, 1888. (Month) (Day) (Year)

7-AGE. 34 yrs. 9 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Herman Wienroeder.

11-BIRTHPLACE OF FATHER, (State or Country). Germany.

12-MAIDEN NAME OF MOTHER, Eliza Drexell.

13-BIRTHPLACE OF MOTHER, (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Reinecke (husband).

(Address) 1100 Warner Street.

15- FILED JAN 12 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 9th, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.
Acute dilatation of the Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Fernbacher M.D. (Coroner.)

Jan. 11, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Westview Cemetery — DATE OF BURIAL: Jan 12 1923

20-UNDERTAKER, Henry Lutz — ADDRESS 1203 N. Broadway

Spec.—1-10-21—M&T—1500 Blks.

D71086

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D71086

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Ward

(a) RESIDENCE NO. 103 W. York St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Will Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Carrie Stewart.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant University Hospital records
(Address)

15 FILED JAN 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from 11/16, 1922, to 1/10, 1923,
that I last saw her alive on Jan. 10, 1923,
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonic Phythisis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home (?)

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W Faccenthe, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct — DATE OF BURIAL Jan 13 1923

20 UNDERTAKER S. H. Brown & Son — ADDRESS 1618 W. Monty

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71087 HEALTH DEPARTMENT—CITY OF BALTIMORE D71087

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

CITY OF BALTIMORE: (No. FORT MCHENRY, BALTO., MD. ST. 28 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME OTTO, Harry T.

(a) RESIDENCE No. 4409 Liberty Heights Ave., Balto., Md. ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) --

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	35	-	-	-

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine Helper

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) -- (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) -- (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown --

13 BIRTHPLACE OF MOTHER (city or town) -- (State or country) Unknown

14 Informant Hospital Records

(Address) Fort McHenry, Baltimore, Md.

15 Filed JAN 12 1923 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1922, to Jan. 11 1923,

that I last saw h im alive on Jan. 11, 1923,

and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic, Far Advanced & Active.

- (duration) - yrs. - mos. - ds.

CONTRIBUTORY (Secondary) --

- (duration) - yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory tests.

(Signed) H S Luse, M. D.

SURGEON (R)

1/11 1923 (Address) Fort McHenry, Balto., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery DATE OF BURIAL Jan 12 1923

20 UNDERTAKER S Lemmon Bro ADDRESS 1127 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71088

D71088

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. ... ST., 16 WARD)

2-FULL NAME Margaretta L. Bradyhouse

(a) RESIDENCE No. 1024 N. Fulton Ave ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 21 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife -

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Thomas Bradyhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda A. Dunn

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Md.

14 Informant Hosp. Records

(Address) ...

15 Filed JAN 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 8 1923. to Jan. 11 1923

that I last saw her alive on Jan. 11 1923

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma ascending Colon

not known (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) ... yrs. ... mos. One ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? yes Date of Jan 9, 1923

Was there an autopsy? no -

What test confirmed diagnosis? Path. findings

(Signed) ... M. D.

1/11/23 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Jan. 15 1923

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71089

CERTIFICATE OF DEATH.

REGISTERED NO. 91-007 D71089

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612-St.Paul-St. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Grace

(a) RESIDENCE NO. 1612-St.Paul-St. ST., 12 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 78 yrs. 2 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Aaron Dyott Grace

6 DATE OF BIRTH (month, day, and year) Oct-29-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Catonsville
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Kimble

11 BIRTHPLACE OF FATHER (city or town) Catonsville
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Frances Sherwood

13 BIRTHPLACE OF MOTHER (city or town) Catonsville
(State or country) Maryland

14 Informant The Misses Grace, (daughters)
(Address) 1612-St.Paul-St., City.

15 Filed JAN 12 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1923

17 I HEREBY CERTIFY, That I attended deceased from October 20th, 1922, to Jan. 11th, 1923.

that I last saw her alive on Jan. 10th, 1923

and that death occurred, on the date stated above, at 11.15 AM m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) 3 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Chronic Asthma Pulmonary Heart Disease from Infancy (duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Clarence Hamilton, M. D.

, 19 (Address) 1 W. Or. Court, Owings Mills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK CEMETERY — DATE OF BURIAL: Jan-13-23

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AV

mation should be carefully supplied. AGE should be stated EXACT
CAUSE OF DEATH in plain terms, so that it may be properly classified
TION is very important. See instructions on back of certificates.

7 ...NS should state ...tatement of OCCUPA... A-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71090

161-001

D71090

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Women's Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Washington Lewis

(a) RESIDENCE NO. Women's Hospital ST., 14 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Jan. 3-1923

7 AGE — Years: 0 — Months: 0 — Days: 6 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Owen B. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Charlestown, West Virginia

12 MAIDEN NAME OF MOTHER: Francis Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charlestown, West Virginia

14 Informant (Address): Owen B. Lewis (Father) 3 Somerset Road, City.

Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1923, to Jan. 9, 1923, that I last saw him alive on Jan. 9, 1923, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

{Prematurity (8 mo.)
{Toxic Icterus Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam

(Signed) G. T. Hoff M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: Jan 12 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

JAN 12 1923

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71091

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D71091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1367 N Stricker ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rickard Taylor

(a) RESIDENCE NO. 1367 N. Stricker ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Blanche Taylor

6 DATE OF BIRTH (month, day, and year): Jan 14, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: John Taylor.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Nancy Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Sarah Mabel.

(Address) 1367 N. Stricker st

15 Filed JAN 12 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1923, to Jan 9th, 1923, that I last saw him alive on Jan 8th, 1923, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar-Pneumonia

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary): not known

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Physical

What test confirmed diagnosis?

(Signed) Harry H. Brown, M. D.

1/10 1923 (Address) 1501 Presstman st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Jan 12 1923

20 UNDERTAKER: Edward Ruggold — ADDRESS: 1463 Carey

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71092

CERTIFICATE OF DEATH.

31

D71092

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1335 Woodyear ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius Freeman

(Residence in Baltimore: No. 1335 Woodyear n St.; 25 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan 1, 1823 (Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Labor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Calvert Co Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Luther Freeman

(Address) 1335 Woodyear St

15- FILED JAN 12 1923, 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 10, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/5 1922, to 1/10 1923, that I saw h in alive on 1/10 1923, and that death occurred, on the date stated above, at 7 4 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. R. Battle M. D.

1-10, 1923 (Address) 2129 W Fay St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, Jan 13, 1923

20-UNDERTAKER Edward Ruggold ADDRESS 1463 Carey

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71093

CERTIFICATE OF DEATH.

31 **D71093**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 Battery Av ST., 24 WARD)

2-FULL NAME Grace E Martin

(a) RESIDENCE NO. 1120 Battery ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dulce Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

067

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Jos C Martin

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Annie Morris

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Jos C Martin
(Address) 1120 Battery Av

15 FILED JAN 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1922 to Jan 9, 1923, that I last saw her alive on Jan 8, 1923, and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M.D.

1/11, 1923 (Address) 1 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 1/11 1923

20 UNDERTAKER E. J. Fanning & Son

ADDRESS 1938 E. Lafayette Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71094

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

D71094

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No 1523 W Pratt 19 St.; WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Elizabeth Grundgrieper

(Residence in Baltimore: No. 1523 W Pratt St. St.; 8 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: December 17, 1855 (Month) (Day) (Year)

7 AGE: 67 yrs. mos. 24 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Christian Grundgrieper

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophia Ebenstein

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sophia Meyer

(Address) 30 ± N. Calhoun St

15. Filed JAN 12 1923 19

ROBERT R. KRAUTER
Burial Permit Clerk
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January 10, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1922, to Jany 10 1923 that I saw h[er] alive on Jany 10, 1923 and that death occurred, on the date stated above, at 9.20 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 2 yrs. mos. 27 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) P Gustav Boll M. D.

Jany 12, 1923 (Address) 1433 W Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: Jan 12, 1923

20 UNDERTAKER: Harry H. Witzke

ADDRESS: 1531 W. London St

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71095 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D71095

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 E. Preston ST., 10 WARD)

2-FULL NAME Bridget L. Sandman

(a) RESIDENCE NO. 725 E. Preston ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry J. Sandman

6 DATE OF BIRTH (month, day, and year) Unknown 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thos. Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Alice Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Henry J. Sandman

(Address) 725 E. Preston St.

JAN 12 1923 ..... 19 Filed Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10" 1923

17 I HEREBY CERTIFY, That I attended deceased from May ..... 19 22, to Jan 10 ..... 19 23,

that I last saw h[illegible] alive on Jany 9 ..... 19 23,

and that death occurred, on the date stated above, at 7" a ..... m.

The CAUSE OF DEATH* was as follows:

Uremia Chronic Nephritis Myocarditis

(duration) ..... yrs. 8 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? usual ones

(Signed) J. J. Kirby, M. D.

1/10, 1923 (Address) 110 S. Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and t2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 1/13" 1923

UNDERTAKER Chas. H. Evans & Son

ADDRESS 1180 W. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D71096

CERTIFICATE OF DEATH

X 100-001 D71096

1 PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 728 W. Lexington St.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexiade Prattyman

(Residence in Baltimore: No. 728 W Lexington St.; yrs. 6 mos. 11 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH: May (Month) 24 (Day) 1922 (Year)

7-AGE: ... yrs. 7 mos. 7 ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE (State or country): Salisbury Md

PARENTS

10-NAME OF FATHER: Louis Prattyman

11-BIRTHPLACE OF FATHER (State or country): Laurel Del

12-MAIDEN NAME OF MOTHER: Mary Bradley

13-BIRTHPLACE OF MOTHER (State or country): Salisbury Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Prattyman

(Address) 728 W Lexington

15- JAN 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Jan (Month) 11 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to, Jan 10 1923, that I saw h.. alive on Jan 10 1923, and that death occurred, on the date stated above, at 4-10A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

one

(Duration) ... yrs ... mos. 3 ds.

Contributory (SECONDARY) .....

(Duration) ... yrs ... mos. ... ds.

(Signed), William H Rusk M. D.

..., 1923 [Address] 742 W Lexington

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: 1/12/23, 191

20-UNDERTAKER: Chas Coumbe

ADDRESS: 11 E Mt Royal

D71097 Duplicate

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D71097

CERTIFICATE OF DEATH. 11-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1043 Harford ave ST. 10 WARD)

2-FULL NAME Laura Shelly

(a) RESIDENCE. No. 901 E. Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/10 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sorter in paper factory

(b) General nature of industry, business, or establishment in which employed (or employer) waste paper

(c) Name of employer Oconnor waste Paper

9 BIRTHPLACE (city or town) (State or country) York Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Kearney

(Address) 1043 Harford ave

15 JAN 12 1923 RUSSELL R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 - 8 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923, to Jan 8, 1923, that I last saw her alive on Jan 8, 1923, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Grippe

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 901 E. Madison St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) J. L. Hornstein, M. D.

1/12. 1923 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: 1/12/23

20 UNDERTAKER: George L. Ruth — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71098

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71098

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 S. Wolfe ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Karol Freszka

(a) RESIDENCE NO. 521 S. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Freszka

6 DATE OF BIRTH (month, day, and year) July 4 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	91	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (day)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Ludwik Freszka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Gorska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Annie Freszka. (Address) # 521 So. Wolfe St.

15 JAN 12 1923 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 6 1923 to Jany 11 1923, that I last saw him alive on Jany 10 1923, and that death occurred, on the date stated above, at 5-30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Terminal)

(duration) yrs. mos 4 1/2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Colet M. Dorsey M. D.

Jan 11 1923 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. Cem.

DATE OF BURIAL Jan. 18 1923

20 UNDERTAKER M. J. Sadowski.

ADDRESS 705 S. Ann St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

15930
D71069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71099

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St., 9 WARD)

2-FULL NAME Grimes Haywood.

(a) RESIDENCE NO. 129 Wilmington St. Raleigh N.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 12 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Williams G. Haywood (Father)

6 DATE OF BIRTH (month, day, and year) Dec 31-1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	11	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School.

(b) General nature of industry, business, or establishment in which employed (or employer) (")

(c) Name of employer (")

9 BIRTHPLACE (city or town) (State or country) Raleigh N.C.

PARENTS

10 NAME OF FATHER Williams G. Haywood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Raleigh North Carolina

12 MAIDEN NAME OF MOTHER Nellie W. Dockery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rockingham N.C.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed JAN 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1922, to Jan 12, 1923, that I last saw him alive on Jan 12, 1923, and that death occurred, on the date stated above, at 11.00 A. m.

The CAUSE OF DEATH* was as follows:

Brain tumor left cerebral
Large infiltrating astrocytic glioma

(duration) yrs. 9 mos ds.

CONTRIBUTORY — (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home Oct 31 1922

Did an operation precede death? Yes Date of Nov 23 1922

Was there an autopsy? Partial Dec 8 1922

What test confirmed diagnosis? Operation

(Signed) H. Cushing M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Raleigh N.C.

DATE OF BURIAL 1-12 1923

20 UNDERTAKER Howard Jenkins & Sons Co

ADDRESS Hillcrest Orchard St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71100

CERTIFICATE OF DEATH.

118-001

D71100

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME Robert Puller

(a) RESIDENCE NO. 407 E Pleasant ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Adam Puller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ursula

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Geo Knull

(Address) 717 Columbia Ave

15 Rec'd JAN 12 1923

ROBERT F. ARNOLD, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 31 ....., 192 2 ....., to Jan 11 ....., 1923 .....,

that I last saw him alive on Jan 11 ....., 1923 .....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Strangulated left inguinal hernia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic insufficiency

Uremia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Phy signs

(Signed) Daniel J Passagno M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan 14 1923

20 UNDERTAKER Knull & Son ADDRESS 1729 E Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71101 001 D71101

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bal Fine Eye Ear & Throat Hospl

CITY OF BALTIMORE: (No.) 625 W. Franklin St. (Ward)

2-FULL NAME Helen Gould Talbott

(a) RESIDENCE. No. Essex Mary Land (If nonresident give city or town and State) Nicholson Road Essex

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 17th 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Variety Store

(c) Name of employer: Kress Variety Store Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: David J. Talbot

11 BIRTHPLACE OF FATHER (city or town) (State or country): Memphis Missouri

12 MAIDEN NAME OF MOTHER: Rosa Neff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D. C.

14 Informant (Address): Rose Talbot (Mother) Robert Ferguson Md

15 Filed . 19 Burial Permit Clerk Registrar

N 1 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from January 8, 1923, to Jan. 10, 1923, that I last saw her alive on January 10, 1923, and that death occurred, on the date stated above, at 11.55 m.

The CAUSE OF DEATH* was as follows:

Brain Abscess

3 weeks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Otitis Media

14 years ? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan 9-23

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Frank A Pacienza M. D.

. 19 (Address) 625 W Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Jan. 13 1923

20 UNDERTAKER: Frank Loschmann Sons — ADDRESS: Fullerton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71102 HEALTH DEPARTMENT—CITY OF BALTIMORE D71102

CERTIFICATE OF DEATH. 19

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Bernice C McLaughlin

(Residence in Baltimore: No. Ellicott City md St.; yrs. ..... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word)
female	white	single

6-DATE OF BIRTH. April (Month) 28 (Day) 1922 (Year)

7-AGE. yrs. 8 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Ellicott City

PARENTS.

10-NAME OF FATHER. Austin McLaughlin

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Berlie Brashears

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Austin McLaughlin

(Address) Ellicott City

15. Robert P. Harrison, 192.....

Burial Permit Clerk. Registrar.

1 12 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan (Month) 11 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns over 60% of body & her clothes started burning after coming in contact with open fire in home

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Kerr M. D. (Coroner.)

Jan 12 1923 (Address) 7002 Chase

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Ellicott City

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL. Mt Clare Cemetery — DATE OF BURIAL. Jan 14 1923

20-UNDERTAKER. Scott M Starr — ADDRESS Ellicott City

(1)—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71103

CERTIFICATE OF DEATH.

84

D71103

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1716 E. 28 ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Ott. Banks

(a) RESIDENCE. No. 1716 E 28 ST., 9 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Boy

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 10, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Mr. Alvin H. Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elma Ott.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant (Address) Alvin H. Banks 1716 E. 28th St.

15 [illegible] Robert P. Harrison, Registrar

JAN 12 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1922 to Jan 10, 1923.

that I last saw h[illegible] alive on Jan 10, 1923.

and that death occurred, on the date stated above, at 3.45-6 m.

The CAUSE OF DEATH* was as follows:

Diabetes
(Latter disease)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. A. Zimmerman M. D.

, 19 (Address) 1808 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Jan 12 23

20 UNDERTAKER ADDRESS

Jos. J. Iden 1566 N. Luzerne

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D71104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71104

CERTIFICATE OF DEATH.

X 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Moore

(a) RESIDENCE. No. Ellicott City, Howard Co. Md. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) N.H.O.

(c) Name of employer

9 BIRTHPLACE (city or town) Laurel, Md.
(State or country)

PARENTS

10 NAME OF FATHER Albert Moore

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Howard County, Md.

12 MAIDEN NAME OF MOTHER Katie American

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Howard County, Md.

14 Informant (Signed) [illegible]
(Address) Worked Md. Pen

15 Filed NOV.-19 F. [illegible], Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January - 7 1923

17

I HEREBY CERTIFY, That I attended deceased from December - 26 - 1922, to January - 7, 1923, that I last saw him alive on January - 7, 1923, and that death occurred, on the date stated above, at 9.15 p. m.

The CAUSE OF DEATH* was as follows:

Toxemia and Exhaustion

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) William H. Schwartz, M. D.

Jan-8, 1923 (Address) Maryland Penitentiary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md.	Jan 12 1923

20 UNDERTAKER ADDRESS

E. B. Hacke 155 E. West St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 12 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71105

CERTIFICATE OF DEATH.

100-001

D71105

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926 W Pratt ST., 20 WARD)

2-FULL NAME Oswald H. Floether

(a) RESIDENCE No. 1925 W Pratt ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

AN

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Floether

6 DATE OF BIRTH (month, day, and year): Feb 4. 1848

7 AGE: Years 74 | Months 11 | Days 7 | If LESS than 1 day, ...hrs. or .....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Taylor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

D8 D

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna E. Andrews

(Address) 1925 W Pratt St.

15 Filed ..... 19 ..... Robert P. [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 4, 1923, to Jany 11, 1923, that I last saw h. in alive on Jany 11, 1923, and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Regular Dill M. D.

1/12, 1923 (Address) 1433 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan. 15 1923

20 UNDERTAKER: C. H. Dill — ADDRESS: 3109 Fredk. Ave.

Spec.—1-10-21—M&T—1500 Bks.

D71106

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71106

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1148 Hand St- ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J Murphy

(a) RESIDENCE NO. 1148 Hand St- ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 11 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Edward J Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto-

12 MAIDEN NAME OF MOTHER Mattie Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fuller Md

14 Informant Mrs Mattie Murphy (Address) 1148 Hand St

15 JAN 12 1923 ROBERT F. [illegible], .19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923 to Jan 11, 1923

that I last saw him alive on Jan 12, 1923,

and that death occurred, on the date stated above, at 3-P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R Chlamporeas M. D.

Jan 12, 1923 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dan Cemetery DATE OF BURIAL Jan 13 1923

20 UNDERTAKER H McCook ADDRESS 932 Mt Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

✓ Fescher 1823 N Washington

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71107

CERTIFICATE OF DEATH.

100-001

D71107

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1809 N. Wolfe ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna D. Hasley

(a) RESIDENCE No. 1809 N. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Uberman Hasley

6 DATE OF BIRTH (month, day, and year) July 3 - 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Robert Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norfolk Va

12 MAIDEN NAME OF MOTHER: Jane Crander

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Wm Hasley

(Address) 1809 N. Wolfe

15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923, to Jan 10, 1923.

that I last saw h[illegible] alive on Jan 10, 1923

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob Frahm, M. D.

1/[illegible], 1923 (Address) 1823 N. Hush St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemty

DATE OF BURIAL: 1/13 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 12 1923

Burial Permit Clerk.

Spec.—8-24-14—M. & T.—2000 Bks.

D71108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71108

CERTIFICATE OF DEATH.

37-602

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1900 W. Lanvale ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Helen E. McGlechen

(Residence in Baltimore: No. 1900 W. Lanvale St.; ...yrs. ...mos. Lifetime ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month) 15 (Day), 1891 (Year)

7-AGE, 32 yrs. 9 mos. 26 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Samuel E. Southard

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Mamie Riley

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Southard

(Address) 253 S. Ct. Balto. St.

15- Robert P. Harris, 1923 191... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jany (Month) 11 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 23 1922, to Jany 11 1923, that I saw her alive on Jany 10 1923, and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

General Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. 3 mos. ds.

(Signed) George C. Shannon M. D.

1/11, 1923 (Address) 700 Fulton ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery DATE OF BURIAL, Jany 15..., 1923

20-UNDERTAKER Harry N. Mumaugh ADDRESS 4204 Ridgewood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71109

CERTIFICATE OF DEATH.

94-007

D71109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3404 Guyon Oak ave ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia G Lambert

(a) RESIDENCE NO. 3404 Guyon Oak ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a ~~Married~~, widowed, ~~or divorced~~ (HUSBAND of ~~or~~) WIFE of Joseph C Lambert

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58.	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carlisle Pa.
(State or country)

PARENTS

10 NAME OF FATHER Chas D Scheckells.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Adaline Hilton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Zimmerman

(Address) 3404 Guyon Oak ave

15 Filed JAN 12 1923 Robert P. Harris Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1923, to Jan 10th, 1923,

that I last saw h~~e~~ alive on Jan 10, 1923,

and that death occurred, on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) A. C. Simmons, M. D.

(Address) 4209 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 1/13/ 1923

20 UNDERTAKER E. J. Fanning & Son

ADDRESS 1468 Battery Ave

mation should be carefully supplied. AGE should be stated EXACTLY. This CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates. OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

160225 D71110

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 D71110

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel S. Keller

(a) RESIDENCE NO. Carneigie Inst. Pittsburgh Pa. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Jerry Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Laura Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 JAN 12 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1923, to Jan 12, 1923, that I last saw him alive on Jan 12, 1923, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with hypertension.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) W. E. Sherman, M. D.

1-12, 1923 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Springfield O. DATE OF BURIAL Jan 12 1923

UNDERTAKER Joseph Ahrens ADDRESS 220 E Way

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71111

CERTIFICATE OF DEATH.

REGISTERED NO. 91-007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Elgin Ave. (was Pennsylvania Ave) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Elizabeth Henry.

(a) RESIDENCE. No. Elgin Ave. (was Pennsylvania Ave) WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Geo. W. Henry.

6 DATE OF BIRTH (month, day, and year) Oct 6th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Wentnick.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Mary A. Henry Elgin Ave. (was Pennsylvania Ave)

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

1 2 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1922, to Jan 12 1923.

that I last saw her alive on Jan 8, 1923.

and that death occurred, on the date stated above, at 1.45 m.

The CAUSE OF DEATH* was as follows:

Arterial sclerosis and cardiac decompensation

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leonard Purnell Bruce M. D.

1, 1923 (Address) 103 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Camp Chapel Cem. Balto Co.	Jan 13th 1923

20 UNDERTAKER ADDRESS

Wilbur W. Shriver 1018 Edmondson Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71112

REGISTERED NO. 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1718 Longwood ST., 15 WARD)

2-FULL NAME Lydia A Cuings

(a) RESIDENCE NO. 1718 Longwood St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of John F Cuings

6 DATE OF BIRTH (month, day, and year): Dec 8 1853

7 AGE: Years 69 Months 3 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co.

PARENTS

10 NAME OF FATHER: John Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Sarah Woolden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant (Address): Jewell E Cuings 1718 Longwood St

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9th, 1923, to Jan 11th, 1923, that I last saw her alive on Jan 11th, 1923, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Isaac C. Dickson. M. D.

, 19 (Address) 3055 W. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery DATE OF BURIAL: Jan 13 1923

20 UNDERTAKER: William Cook Sons ADDRESS: 1102 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

12 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71113

CERTIFICATE OF DEATH.

31 D71113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 615 Falls Road Terrace 27 WARD)

2-FULL NAME Kathrine L. Smith

(a) RESIDENCE. No. 615 Falls Road Terrace ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Smith

6 DATE OF BIRTH (month, day, and year) Feby 10th 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress Maker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James Lindermann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Louis Kline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland

14 Informant (Address) Mrs Louis Lindermann 615 Falls Road Terrace

15 Filed Jan 11 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1922, to Jan 10, 1923, that I last saw h[er] alive on Jan 9th, 1923, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis. (was an arrested case which recently became activ again) (duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Finding tubercle bacilli

(Signed) Wm J Watson, M. D.

Jan 11, 1923 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL: 1/13 1923

20 UNDERTAKER: Liston P. Fusselbaugh — ADDRESS: 2620 St Paul

1 2 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71114

D71114

91-02

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 Altoona ave ST. 77 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H Loeller

(a) RESIDENCE NO. 18 Altoona AVE ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: Sarah E Loeller

6 DATE OF BIRTH (month, day, and year): Sept 23 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Sarah E. Loeller 18 Altoona ave

15 1 12 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1922, to Jan 11, 1923, that I last saw him alive on Jan 10, 1923 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White Jr M. D.

1/12, 1923 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 1/13 19 23

20 UNDERTAKER: Henry Lutz

ADDRESS: 1203 Pennsylvania

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71115

CERTIFICATE OF DEATH.

31

D71115

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1294 E. Baltimore ST. 26 (WARD)

2-FULL NAME Mary E. Hurst

(a) RESIDENCE NO. 1294 E. Baltimore ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) married

5a If married, widowed, or divorced (or) WIFE of Samuel M. Hurst

6 DATE OF BIRTH (month, day, and year) Jan 31 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) Samuel M. Hurst 1294 E. Baltimore

15 Filed ..... 19 ..... Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 11 1922, to Jan 10 1923.

that I last saw her alive on Jan 9 1923,

and that death occurred, on the date stated above, at 11:45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward S. Cook, M. D.

1/11, 1923 (Address) 413 N. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster

DATE OF BURIAL 1/13 1923

ADDRESS .....

20 UNDERTAKER Lee G. Cook Undertaker

mation should be carefully supplied. AGE should be stated EXACTLY. Physicians are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 12 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71116

CERTIFICATE OF DEATH.

100-001

D71116

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1173 Washington Blvd ST. 21 WARD)

2-FULL NAME Mary Elizabeth Ratcliff

(a) RESIDENCE. NO. 1173 Wash. Blvd. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 12 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Lee Ratcliff

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Halaway

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Emma Halaway
(Address) 1173 Washington Blvd

15 Filed JAN 13 1923 Registrar

JAN 13 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to Jan 11, 1923, that I last saw her alive on Jan 11, 1923, and that death occurred, on the date stated above, at 6 50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stanley Strong, M. D.

1/12 1923 (Address) 727 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Jan 13 1923

20 UNDERTAKER John J. Fields ADDRESS 100 N Gorsuch Ave

mation should be given. Any should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71117

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 W Franklin ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Frances Maxfield

(a) RESIDENCE. No. 1625 W Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mitchell Maxfield

6 DATE OF BIRTH (month, day, and year) June 17, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER David Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co

12 MAIDEN NAME OF MOTHER Mary Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md

14 Informant Dora Hanks
(Address) 1625 W Franklin St

15 Filed JAN 13 1923 Robert P. Harris... Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 10 1923

17 I HEREBY CERTIFY, That I attended deceased from January 6, 1923, to June 10, 1923, that I last saw her alive on June 9, 1923, and that death occurred, on the date stated above, at 11:15 A. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Age - Arteriosclerosis
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H Wright M. D.

Jan 10, 1923 (Address) 1209 Presbman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 1/13 1923

20 UNDERTAKER Samuel T Shanley — ADDRESS 578 W Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 13 1923

Spec.—8-24-14—M. & T.—2000 Bks.

D71118

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71118

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 N. Eden St.; 5 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman Chester

(Residence in Baltimore: No. 212 N. Eden St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH, June (Month) 26 (Day), 1898 (Year)

7-AGE, 24 yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ship Caulker
(b) General nature of industry, business, or establishment in which employed (or employer): U.

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Jeremiah Chester

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Josephine Dubois

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Josephine Chester (Mother)

(Address) 212 N Eden st

15-

Filed Robert F. Harrison, Registrar.

1 3 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 11 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1922, to Jan 11 1923, that I saw him alive on Jan 10 1923, and that death occurred, on the date stated above, at 1.15 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.

(Duration) ....yrs. 5 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) R. J. Young M. D.

1/12, 1923. (Address) 1429 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel

DATE OF BURIAL. Jan. 14, 1923

20-UNDERTAKER John W Henderson

ADDRESS 1602 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71119

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71119

CERTIFICATE OF DEATH.

118-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hosp. ST., 1 WARD)

2-FULL NAME Margaret Rittenpusch

(a) RESIDENCE No. 3006 Hudson ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 11 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Mrs. Rittenpusch

6 DATE OF BIRTH (month, day, and year) Jan. 14th 18

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER John Bolmer

11 BIRTHPLACE OF FATHER (city or town) Germany. (State or country)

12 MAIDEN NAME OF MOTHER Anna Brady.

13 BIRTHPLACE OF MOTHER (city or town) U.S. (State or country)

14 Informant Henry Rittenpusch (Son) (Address) 3006 Hudson St.

15 Filed Jan 13 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1923, to Jan. 10, 1923, that I last saw her alive on Jan. 10, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction due to strangulated umbilical hernia (duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 1-10-23

Was there an autopsy? No

What test confirmed diagnosis? Laparotomy

(Signed) J. V. Szyrbicki M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Jan. 13th 1923

20 UNDERTAKER Lilly + Zeller — ADDRESS 403 S. Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71120

CERTIFICATE OF DEATH.

74-001

D71120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 337 S. Calhoun St. ST., 19 WARD)

2-FULL NAME John Henry Lee

(a) RESIDENCE NO. 337 S. Calhoun St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lee

6 DATE OF BIRTH (month, day, and year) Aug. 18" 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER William Beal Lee

11 BIRTHPLACE OF FATHER (city or town) Baltimore Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Ann Read

13 BIRTHPLACE OF MOTHER (city or town) Janettesill e
(State or country) Md.

14 Informant John Harry Lee
(Address) 337 S. Calhoun St.

15 Filed Jan 13 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 10" 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to Jan 10, 1923.

that I last saw him alive on Jan 10, 1923.

and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? only symptoms

(Signed) H. E. Krupp M. D.

1/11 1923 (Address) Fremont Ave. & Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 13" 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Gate

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Medical Examiner should be currently supplied. AGE should be stated EXACTLY. PHYSICIANS should use

Spec.—1-10-21—M&T—1500 Bks.

D. 71121

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 71121

CERTIFICATE OF DEATH.

3118-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 S. Dallas ST., 3 WARD)

2-FULL NAME Catherine Hammel

(a) RESIDENCE NO. 719 S. Dallas ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry P. Hammel

6 DATE OF BIRTH (month, day, and year) Feb 24, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER William Roberts

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie M Meyer

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Emma Kundt

(Address) 719 S. Dallas St

15 Filed Jan 13 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1923 to Jan 12 1923.

that I last saw her alive on Jan 11 1923

and that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Constipation

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John H. Kehlberger, M. D.

19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. DATE OF BURIAL Jan 15 1923

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Eden St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71122

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71122

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 Boyd Street ST. 18 WARD)

REGISTERED NO. 74002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Joyce

(a) RESIDENCE NO. 1012 Boyd Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Nolan Joyse

6 DATE OF BIRTH (month, day, and year) Unknown 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman at Water

(b) General nature of industry, business, or establishment in which employed (or employer) Department

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Catherine Joyse

(Address) 1012 Boyd St.

15 Filed Robert P. Harrison, Registrar

JAN 13 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1922, to Jan. 10, 1923, that I last saw him alive on Jan. 10, 1923 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edward H. Cowman M. D.

1/13, 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Jan 15 1923

20 UNDERTAKER: John J. Cowan & Son 901 — ADDRESS: Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71123

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71123

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 525 S. Charles St. St. 22 167 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George J. Miller.

34

(Residence in Baltimore: No. 525 S. Charles St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White.

5-Single, Married, Widowed, or Divorced. (Write the word.): Widower.

6-DATE OF BIRTH: June 20th. 1857. (Month) (Day) (Year)

7-AGE: 65 yrs. 6 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Box maker.
(b) General nature of industry, bnsiness, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Philadelphia, Pa.

PARENTS.

10-NAME OF FATHER: John Miller.

11-BIRTHPLACE OF FATHER, (State or Country): Germany.

12-MAIDEN NAME OF MOTHER: Bertha. ----------

13-BIRTHPLACE OF MOTHER, (State or Country): Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Bradley (daughter)

(Address) 30 E. Heath St.

15- Robert P. Harrison,

Filed ..... 192.....

Registrar.

N 131923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 11th. 1923. (Month) (Day) (Year) 192.....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas Asphyxia.

Suicide.

(Duration) ....yrs. ....mos. ....ds.

a. CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Jany 12, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cedar Hill

DATE OF BURIAL, 1-15 192.3

20-UNDERTAKER: Wm. Cook

ADDRESS 502 E. North

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D71124

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71124

CERTIFICATE OF DEATH.

99-00

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 422 N. Greene ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carmela Geppi

(Residence in Baltimore: No. 422 N Greene st St.; ....yrs. ....mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, Dec. 30, 1922 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. 14 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy and

PARENTS.

10-NAME OF FATHER, Rosario Geppi

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosolia Geppi

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosolia Geppi

(Address) 422 N. Greene st

15-

Robert F. Harrison,

Filed....., 191.....

Registrar.

JAN 13 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 13, 1923 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Jan 9 1923, to Jan 13 1923, that I saw h[illegible] alive on Jan 13 1923 and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

ac. bronchitis

4

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

....., 191... (Address) 210 East st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Jan. 13, 1923

20-UNDERTAKER W M Poulson

ADDRESS 230 N Greene

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D71125

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71125

CERTIFICATE OF DEATH.

1 X 90

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward F. Jones (one minutes)

(Residence in Baltimore: No. Chesterton. Md St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept 2nd (Month) (Day) 1866 (Year)

7-AGE, 56 yrs. 4 mos. 9 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Alexandria Va

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Henrietta Baker

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ada Brown

(Address) Chesterton Md

15-

Filed Jan 13, 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 11, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains deserbed above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia
Duration 2 yrs. Valvular heart
Duration yrs. mos. ds.
CONTRIBUTORY (Secondary) a Cell Carcinoma
Duration yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Jan 11, 1923 (Address) 1039 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State 40 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Chesterton Md

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Jan 15, 1923

20-UNDERTAKER [illegible]

ADDRESS 1223 E. Lafayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71126

CERTIFICATE OF DEATH.

10-F-001 D71126

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 110 N. Calhoun St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Susan Cummings

(a) RESIDENCE. No. 110 N. Calhoun St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles Albert Cummings

6 DATE OF BIRTH (month, day, and year) Apr 13 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59.	8	30.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house-wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Talbott Co, Md.

PARENTS

10 NAME OF FATHER John H. Jones.

11 BIRTHPLACE OF FATHER (city or town) Talbott Co, (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosa Jackson.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

11 Informant Charles Albert Cummings

(Address) 110 N. Calhoun St.

15 Filed 1 13 1923 19 Robert F. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12 1923

17 I HEREBY CERTIFY, That I attended deceased from January 8 1923, to January 13, 1923, that I last saw h.. alive on January 12 1923 and that death occurred, on the date stated above, at 6:05 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Chester Leland, M. D.

1-14-, 19- (Address) 253 E Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville

DATE OF BURIAL: 1-14 1923

20 UNDERTAKER: H. C. Browning & Son

ADDRESS 617 N. Edmondson St.

Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71127

D71127

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH St. Agnes Hosp—

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ella McLaughlin

(a) RESIDENCE NO. 2017 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, ~~widowed, or divorced~~ (or) WIFE of: Chas. McLaughlin

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Samuel P. Coulter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Jane Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Charles McLaughlin

(Address): 2017 W Mulberry St

15 JAN 13 1923 Robert P. Harris, ..., 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-12 1923

17

I HEREBY CERTIFY, That I attended deceased from 1-12- , 1923. to 1-12- , 1923.

that I last saw h-r alive on 1-12 , 1923

and that death occurred, on the date stated above, at 7:20 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with acute Exacerbation

Not Known (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremic Coma Cardiac failure (duration) Several days yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No—

What test confirmed diagnosis? Clinical

(Signed) W. C. Caldwell M. D.

JAN 13 1923 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: JAN 15 1923

17

20 UNDERTAKER: Geo W Little

ADDRESS 2700 EDMONDSON AVE.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71128

CERTIFICATE OF DEATH.

129 D71128

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 14 WARD)

2-FULL NAME Harry H. Ogle

(a) RESIDENCE NO. 1513 John St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records. (Address)

15 Robert P. Harrison, Burial Permit Clerk. Registrar

JAN 13 1923 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from November 12 1921 to January 12 1923.

that I last saw him alive on January 12, 1923,

and that death occurred, on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mental depression

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. McKay, M. D.

1/13/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park DATE OF BURIAL JAN 15 1923 19

20 UNDERTAKER Geo W Little ADDRESS 2709 EDMONDSON AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 13 1923

Spec.—8-24-14—M. & T.—2000 Bks.

D71129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71129

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1547 Clifton Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella C Smit

(Residence in Baltimore: No. 1547 Clifton Ave St.; 6 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: W Rite

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Dec (Month) 3 (Day) 1859 (Year)

7-AGE: 63 yrs. 1 mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: James R Baylis

11-BIRTHPLACE OF FATHER (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Elizabeth Haynes

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm F. Smit

(Address) 1547 Clifton Ave

15- Robert P. Harrison,

Filed ....., 191.....

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 12 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 1923, to Jan 12 1923, that I saw h er alive on Jan 12 1923, and that death occurred, on the date stated above, at 9.50 A.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frith J. Sewell M. D.

Jan 13., 1923 (Address) 2516 Pennsylvania Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western

DATE OF BURIAL, JAN 15 1923, 191.....

20-UNDERTAKER Geo W Little

ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 13 1923

Spec.—1-10-21 M&T 1500 Blks.

D71130

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71130

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 855 Greenmount Ave ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Smallwood

(a) RESIDENCE NO 855 Greenmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	0	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Harvey L Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Edna Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edna Miller

(Address) 855 Greenmount Ave

15 Filed ....., 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1923, to Jan 13, 1923.

that I last saw her alive on Jan 12, 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. 0 mos 1 ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Coroner

(Signed) W. Reamy M. D.

Jan 13, 1923 (Address) 24 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Jan 13 1923

20 UNDERTAKER Ebenezer Sons — ADDRESS Chestnut Ave

JAN 13 1923

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D71131 HEALTH DEPARTMENT—CITY OF BALTIMORE D71131

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grant Dashields

(a) RESIDENCE NO. 519 Bruce St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	25	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Salisbury, Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Dashields

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Municipal Hospital Records.
(Address)

15 Robert F. Harrison Registrar

1/13 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 9 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 8, 1923, to January 9, 1923, that I last saw him alive on January 9, 1923, and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde M. Smith M. D.

1/10/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL January 13 1923

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Ashland Ave

Attention should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71132 D71132

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Holbrook ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Thompson

(a) RESIDENCE NO. 1209 Holbrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth 1 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 9 1922

7 AGE — Years: — Months: 9 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: David E Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: Gertrude Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: David E Thompson

(Address) 1209 Holbrook St

15 Filed JAN 13 1923

Robert F. Harrison, Registrar

Burial Permit Clerk.

N. B.—mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 11, 1923, to Jan 13, 1923,

that I last saw her alive on Jan 12, 1923,

and that death occurred, on the date stated above, at 3 15 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia 1 month ago (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) O. B. Carman, M. D.

1-13-1923 (Address) 1707 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patricks St Vincents

DATE OF BURIAL: Jan 15 1923

UNDERTAKER: William Cook

ADDRESS: 562 E North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

Funeral will be 4.30 P.m.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71133 D71133

CERTIFICATE OF DEATH.

10

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 S. Bond ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ferdinand Sedlik

(a) RESIDENCE. No. 829 S. Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ~~Sept~~ 3 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 4, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Bridgeport (State or country) Conn.

PARENTS

10 NAME OF FATHER Ignaci Sedlik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Julia Will

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant M. F. Sadowski

(Address) 705 S. Ann St

15 Filed JAN 13 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1923, to Jan. 12, 1923, that I last saw him alive on Jan. 12, 1923, and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac paralysis

(duration) yrs. mos. 15 days.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? intubation Jan. 12/23 Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A T Pace, M. D.

Jan 13 1923 (Address) 245 S. Bonny

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Jan. 13, 1923.
20 UNDERTAKER	ADDRESS
M. F. Sadowski	705 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 13 1923

Spec.—1-10-21—M&T—1500 Blks.

D71134

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71134

CERTIFICATE OF DEATH.

154-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 12 McHail (ST.) 20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Marie Kerr

(a) RESIDENCE NO. 12 McHail St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 16-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER James Kerr

11 BIRTHPLACE OF FATHER (city or town) Prince George Co (State or country) Md

12 MAIDEN NAME OF MOTHER Irene Garlock

13 BIRTHPLACE OF MOTHER (city or town) Pocomoke City (State or country) Maryland

14 Informant James Kerr (Address) 12 McHail St

15 Filed Sept 13 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1922, to June 12, 1923, that I last saw h[illegible] alive on June 11, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH was as follows:

Pneumothorax

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Hydrocephalus Congenital

Pneumonia (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

June 13, 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL June 13 1923

20 UNDERTAKER George L. Schmaltz — ADDRESS 710 Fulton Ave

13 1923

mation should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71135

CERTIFICATE OF DEATH.

4161-001

D71135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: W WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gudaitis

(a) RESIDENCE. No. 707 N Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Jan. 13-1923

7 AGE	Years	Months	Days	If LESS than 1 day 1/24 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Jonas Gudaitis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Petronelle Pilipovicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Petronelle Gudaitis

(Address) 707 W. Lombard St.

15 Filed 1 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1923, to Jan. 13, 1923, that I last saw h[illegible] alive on January 13, 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity (26 weeks)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Anthony V. Buchman M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 13 1923

20 UNDERTAKER John Grebliunckas ADDRESS 426 S. Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DIAGNOSIS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71136 38 D71136

CERTIFICATE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Morrow Hospital
CITY OF BALTIMORE (No. 1122 N. Mount ST. 4 WARD)

2-FULL NAME Thomas J. Milligan

(a) RESIDENCE No. 415 St Paul Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Turner

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 60 | Months: ? | Days: ? | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Trunk maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer C. J. Dunn & Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Thomas J Milligan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER Mary Dondra

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mary T. Milligan
(Address) 415 St. Paul Pl

15 Filed 1 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-12-1923

17 I HEREBY CERTIFY, That I attended deceased from 10-27-1922 to 1-12-1923.
that I last saw him alive on 1-12-1923
and that death occurred, on the date stated above, at 2 p/m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 25 yrs mos ds

CONTRIBUTORY (Secondary) Acute bronchitis
(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Howard R Tolson M. D.
, 19 (Address) 1325 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 1/13 1923

20 UNDERTAKER: Henry W. Maus & Son — ADDRESS: 805 N. Calvert St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See Letter Attached) V

~~54137~~ HEALTH DEPARTMENT—CITY OF BALTIMORE ~~54137~~

D71137

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

38 D71137

REGISTERED No.

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Rose (Miguel Rosa Santa)

(a) RESIDENCE No. 921 E. Madison St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Portugal

PARENTS

10 NAME OF FATHER: Manuel Rose (Santa)

11 BIRTHPLACE OF FATHER (city or town) (State or country): Portugal

12 MAIDEN NAME OF MOTHER: Rosa Santa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Portugal

14 Informant: Municipal Hospital Records. (Address)

15 Filed JAN 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 11 19 23

17

I HEREBY CERTIFY, That I attended deceased from January 3, 19 23 to January 11, 19 23.

that I last saw him alive on January 11, 19 23,

and that death occurred, on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 27 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Refused

What test confirmed diagnosis? Wassermann - Sachs-Georgi

(Signed) Clyde M. Neill, M. D.

1/12/19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Providence R. I. DATE OF BURIAL: Jan 14 19 23

20 UNDERTAKER: Chas. H. Jenson & Co. ADDRESS: 46 N. Carpline St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEPARTMENT OF CHARITIES AND CORRECTIONS
SUB-DEPARTMENT
SUPERVISORS OF CITY CHARITIES

GEORGE R. McCLEARY,
SUPERINTENDENT
W. H. CURRY,
ASST. SUPERINTENDENT

CITY OF BALTIMORE
MARYLAND
MUNICIPAL DEPARTMENTS

BAY VIEW HOSPITAL
HIGHLANDTOWN P. O.

January 18, 1923

To the Bureau of Vital Statistics;

A death certificate was recent made out for Michael Rose, who died January 11, 1923. The correc name of this patient should be Miguel Rosa Santa.

Resident Physician.

CMcN/MAH.

Spec.—1-10-21—M&T—1500 Bks.

Ma Bee

71138

HEALTH DEPARTMENT—CITY OF BALTIMORE

71138

D71138

CERTIFICATE OF DEATH.

94-001

D71138

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 504 N. Schroeder ST. 18 WARD)

2-FULL NAME Alexander MaBee

(a) RESIDENCE NO. 504 N. Schroeder ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lula V MaBee

6 DATE OF BIRTH (month, day, and year): Dec 23 1868

7 AGE: Years 54 Months Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles MaBee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Attaskuscon Pa

12 MAIDEN NAME OF MOTHER: Mary Steichs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Lula V MaBee

(Address) 504 N Schroeder

15 JAN 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1923, to Jan 12, 1923, that I last saw h alive on Jan 11, 1923, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Haemaplegia left (Cerebral Hemorrhage)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Paralysis

(Signed) H. E. Krauth M. D.

Jan 13, 1923 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem DATE OF BURIAL: Jan 15 1923

20 UNDERTAKER: William Cook ADDRESS: 512 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71139

D71139

REGISTERED NO.

PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Parker.

(a) RESIDENCE. NO. 1036 Falls Road ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 10 - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER W. C. Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Parks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Parker

(Address) 1036 Falls Rd

15 FILED JAN 14 1923 ROBERT R. KRAUTER Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to Jan 12, 1923, that I last saw h alive on Jan 12, 1923, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH was as follows:

Diphtheritic, nasal, tonsillar & pharyngeal.

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Cultures (+)

(Signed) Bluggerman, M. D.

1/13/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden

DATE OF BURIAL Jan 14 192

20 UNDERTAKER E. L. Roy Stiffler

ADDRESS 125 North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D71140

1-PLACE OF DEATH Maternity Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 14 WARD)

2-FULL NAME Sarah Cohen Clay

(a) RESIDENCE NO. 1711 Madison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Clay

6 DATE OF BIRTH (month, day, and year) 1-9-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dr Wm A. Wales

1711 Madison Ave

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Frederick Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Nellie Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Hospital Records

(Address)

15 JAN 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-9 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-7, 1923, to 1-9, 1923,

that I last saw her alive on 1-9, 1923,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Paralysis cerebral

embolus of right

middle cerebral artery.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) W. V. Vaccaro, M. D.

, 19 (Address) Maternity Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mila, Northumberland Co. Va

DATE OF BURIAL Jan 14 1923

20 UNDERTAKER Harry H. Witzke

ADDRESS 1531 W. Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework.* or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook. Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

~~no other history~~
Probably Inflammatory
Rheumatism —
Acute & Chronic Endocarditis

Usher

HEALTH DEPARTMENT--CITY OF BALTIMORE

D71141
1 PLACE OF DEATH

CERTIFICATE OF DEATH

49

D71141
REGISTERED No. C .....

CITY OF BALTIMORE (No. 516 E 21st St.; 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Richard Usher

(Residence in Baltimore: No. 516 E 21st St.; 50 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Sept (Month) 9 (Day), 1852 (Year)

7 AGE: 70 yrs. 4 mos. 13 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Ireland

PARENTS

10 NAME OF FATHER: Richard Usher

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Murphy

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Usher
(Address) 516 E 21st St

15 Filed JAN 14 1923
ROBERT R. KRAUTER, Burial Permit Clerk.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 12 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Jan 12 1923
that I saw h— alive on Jan 12, 1923,
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate Gland.

(Duration) ..... yrs. 2 mos. ..... ds

Contributory (SECONDARY) Hypostasis

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) James M Benton M. D.
Jan 13, 1923 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Cathedral — DATE OF BURIAL: Jan 16, 1923

20 UNDERTAKER: E A Wedefeld — ADDRESS: 501 E 22 St

Spec.—1-10-21—M&T—1500 Bks.

D71142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001

D71142

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2524 E. Biddle ST., 8 WARD)

2-FULL NAME Martha C. Morrison

(a) RESIDENCE NO. 1524 E. Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Sanford H. Morrison

6 DATE OF BIRTH (month, day, and year): Nov 3, 1870

7 AGE — Years: 52 — Months: 2 — Days: 9 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Morris B. Slawson

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER: Sophie R. Silverman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Sanford H. Morrison
(Address) 2524 E. Biddle

15 Filed JAN 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to Jan 12, 1923,
that I last saw h[illegible] alive on Jan 12, 1923
and that death occurred, on the date stated above, at 7.20 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible], M. D.
Jan 13, 1923 (Address) 1201 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Crems — DATE OF BURIAL: Jan 16 1923

20 UNDERTAKER: Funkler & Buckler — ADDRESS 1799 Eager St

Spec.—1-10-21—M&T—1500 Bks.

D71143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D71143

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 E. Chase ST., 1 WARD)

2-FULL NAME Josephine Wright

(a) RESIDENCE No. 2011 E. Chase ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John T. Wright

6 DATE OF BIRTH (month, day, and year): Sept 16 1839

7 AGE — Years: 82 — Months: 3 — Days: 28 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Geo. W. Price

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Raddish

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Sadie T. Wright

(Address): 2011 E. Chase

15 JAN 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1922, to Jan. 13, 1923.

that I last saw h e alive on Jan 12, 1923.

and that death occurred, on the date stated above, at 9.20A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and Aortic regurgitation

..... (duration) ..... / yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert S. Engeldd, M. D.

1/13, 1923 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL: Jan 15 1923

20 UNDERTAKER: Zurkler & Zickler — ADDRESS 1739 Eager st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71144

CERTIFICATE OF DEATH.

74-001 D71144

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Haywood ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M Krager.

(a) RESIDENCE NO. 615 Haywood ST., ... WARD ...

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank H H Krager

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 69 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington DC

PARENTS

10 NAME OF FATHER: Hagerty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington DC

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Arthur M Krager

(Address): 615 Haywood ave

15 Filed JAN 14 1923 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 12 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1923 to Jan 12, 1923,

that I last saw h alive on Jan 11, 1923

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Paralysis Intestinal tract

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A Evans M. D.

, 19 (Address) 101 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Jan 8 1923

20 UNDERTAKER: H M Rountree — ADDRESS: 2235 W North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Hemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

Caleb E Henry

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71145

CERTIFICATE OF DEATH.

74-001

D71145

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1318 Hollins St. (WARD) 11

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caleb E Henry

(a) RESIDENCE. No. 1318 Hollins St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Eliza Henry

6 DATE OF BIRTH (month, day, and year): Jan 17 44

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Harry E Henry ert

(Address) 1318 Hollins St

15 Filed JAN 14 1923 ROBERT R. KRAMER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/12/23 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 1-23, 19..., to Jan 12, 19 23,

that I last saw him alive on 1/11/23, 19...,

and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) T. H. Wenzke, M. D.

1/13/23 (Address) 1302 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Park Cemetery	Jan 15 1923

20 UNDERTAKER: H. M. Poulson

ADDRESS 2258 N Broadway

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71146

CERTIFICATE OF DEATH.

74-001 D71146

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 115 North Front. ST. 5 WARD)

2-FULL NAME George Powell.

(a) RESIDENCE. No. 115 North ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife Josephine Grace Powell
Can not get this information at present

6 DATE OF BIRTH (month, day, and year) Jan 21-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Fishmarket

(c) Name of employer J. Harry Sauers

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER George C. Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Germany

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Josephine Grace Powell (Widow)
(Address) 115 N Front St

15 FILED JAN 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 11th 1923

17 I HEREBY CERTIFY, That I attended deceased from January 11th, 1923, to January 11th, 1923, that I last saw him alive on January 11th, 1923, and that death occurred, on the date stated above, at about 12 m.

The CAUSE OF DEATH* was as follows:

Apoplexy. Preceded by an attack of acute indigestion.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Manifest Symptoms

(Signed) D. L. Woodward, M. D.

, 19 (Address) 6 North Front St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 15 1923

20 UNDERTAKER
MR. & MRS. N. S. FINK,
FUNERAL DIRECTORS
1038 W. PRATT STREET.

ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71147

CERTIFICATE OF DEATH.

100-002

D71147

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2910 Hudson ST., 1 WARD)

2-FULL NAME Jacob P. Kahler

(a) RESIDENCE NO. 2910 Hudson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Dec 9- 1922

7 AGE — Years | 1 Months | 6 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): none.

(c) Name of employer: none.

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Jacob P. Kahler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Barbara Palanuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Jacob P. Kahler.
(Address) 2910 Hudson

15 Filed JAN 14 1923, 19.. ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1923, to Jan 13, 1923, that I last saw him alive on Jan 13, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) asphyxia (accidental)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. V. V. Wright, M. D.

1/17, 1923 (Address) 1015 N. Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: 1/15 1923

20 UNDERTAKER: Wm Faehrmann

ADDRESS: 118 Eastern Ave.

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71148

CERTIFICATE OF DEATH.

74-001

D71148

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 404 Hawthorn Road ST., 27 WARD)

2-FULL NAME Josephine Hanson Glanville

(a) RESIDENCE NO. 404 Hawthorn Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Bolton Glanville

6 DATE OF BIRTH (month, day, and year) April 9, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	73	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William Joyce

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eleanor Gardner

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Josephine Glanville (Address) 404 Hawthorn Road

15 Filed JAN 14 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-12-1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1923, to Jan-12, 1923,

that I last saw h alive on Jan-12, 1923,

and that death occurred, on the date stated above, at 4-5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

30 min.

(duration) - yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Arterial sclerosis

(duration) 3 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) M. Gibson Forbes M. D.

1/14, 1923 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 1/15 1923

20 UNDERTAKER Henry W. Mears & Son — ADDRESS 805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Blks.

71149

D71149

1-PLACE OF DEATH

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

71148 D71149

X 71-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1817 Smallwood ST., 15 WARD)

2-FULL NAME Thomas Luther Stine.

(a) RESIDENCE NO. 1817 Smallwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara M Stine.

6 DATE OF BIRTH (month, day, and year) Sept 28 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	66	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Amusement

(b) General nature of industry, business, or establishment in which employed (or employer) Business,

(c) Name of employer

9 BIRTHPLACE (city or town) Rohrsville Md.
(State or country)

PARENTS

10 NAME OF FATHER Josiah Stine.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Locust Grove, Washington Co. Md

12 MAIDEN NAME OF MOTHER Elizabeth Rohrer.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Locust Grove, Md

14 Informant Mr Herbert G Stine.
(Address) Maryland (Rear) Hagerstown

15 JAN 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 14, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jany 1, 1923. to Jany 14, 1923.

that I last saw h[illegible] alive on Jany 14, 1923.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis, pon.

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Hiccoughs.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Don't know.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe M. D.

, 19 (Address) 424 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rohrsville Md — DATE OF BURIAL Jan 14 1923

20 UNDERTAKER Wm J. Tucker & Sons — ADDRESS N. & T. ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

The deceased had
Cerebro-spinal
Meningitis at 5 yrs.
I feel that death resulted
indirectly from relighting of
the old trouble.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71150 94-00171150

CERTIFICATE OF DEATH.

D71150

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 E. West ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Myers

(a) RESIDENCE. NO. 3 E. West ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Myers

6 DATE OF BIRTH (month, day, and year) Jan 6 - 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Engelman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Frank Myers

(Address) 3 E. West St.

15 Filed JAN 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 12, 1923, that I last saw h alive on Jan 12 1923, and that death occurred, on the date stated above, at 8:30 Pm m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 1/2 mos. day ds.

CONTRIBUTORY (Secondary) Chronic Nephritis 12 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of -

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry B Holt, M. D.

1923 (Address) 1202 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 15 1923
20 UNDERTAKER	ADDRESS
F. A. Trance & Son	1039 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

71151 HEALTH DEPARTMENT—CITY OF BALTIMORE 71151

D71151 CERTIFICATE OF DEATH. 45 D71151

1-PLACE OF DEATH Church Home + Infirmary — REGISTERED NO.

CITY OF BALTIMORE: (No. ~~309~~ N. Broadway — ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Kate Harig —

(a) RESIDENCE NO. 309 Mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard L. Harig

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Irene T. Freebuerger

(Address) 2903 Harlem ave

15 FILED JAN 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922, to Jan 11, 1923, that I last saw h[illegible] alive on Jan 11, 1923, and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Caecum

Carcinoma of Sigmoid

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) None —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of

Was there an autopsy? Yes —

What test confirmed diagnosis? Operation

(Signed) Kate L. Rice M. D.

, 19 (Address) Church Home, Bty —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 15 1923
20 UNDERTAKER	ADDRESS
F.A. Fraser & Son	705 Hanover St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Francis Burgan

71152

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71152

CERTIFICATE OF DEATH.

125

71152

D71152

1-PLACE OF DEATH Md General Hospital

CITY OF BALTIMORE: (No. ..... ST., 29 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Burgan

(a) RESIDENCE NO. 21 Hamilton Ave. WARD Raspeburg

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Sept. 22nd 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER Howard L. Burgan

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Tindall

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Maryland

14 Informant Clarence E. Burgan

(Address) 21 Hamilton ave. Raspeburg

15 Filed JAN 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1922 to Jan 13, 1923, that I last saw h— alive on Jan 1, 1923, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH was as follows:

1. Hypertrophy of Prostate gland

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Dec 28-22

Was there an autopsy? No

What tests confirmed diagnosis? Clinical

(Signed) James H. Wilkinson M. D.

19 (Address) Md Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Jan. 15 1923

20 UNDERTAKER Fredk Lassahn & Sons — ADDRESS Fullerton

Spec.—1-10-21—M&T—1500 Bks.

D71153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 5 D71153

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospital ST., WARD)

2-FULL NAME Jno W Hammond

(a) RESIDENCE NO. Sykesville Md ST., WARD Sykesville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary A. Hammond

6 DATE OF BIRTH (month, day, and year) Sept 20, 1854

7 AGE: Years 68 yrs; Months 3 mo; Days 25 da; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self Employed

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md.

PARENTS

10 NAME OF FATHER Philip J. Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Hagan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary A. Hammond. (Address) Sykesville Md.

15 Filed JAN 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/14/23

17 I HEREBY CERTIFY, That I attended deceased from 9/19/23, to 1/14/23, 19.....

that I last saw h[illegible] alive on 1/14/23 at 5 p.m.

and that death occurred, on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows: Hypertrophy Prostate

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) ? yrs. ..... mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 1/12/23

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Findings

(Signed) James Hubert Waterman M. D.

(Address) Md Sta Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sykesville Md. DATE OF BURIAL: Jan 17 1923

20 UNDERTAKER: Jas. R. Hess ADDRESS: Sykesville Md.

matlon should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71154

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Josephs Hosp St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Elsta Jones

(Residence in Baltimore: No. 30 Spring St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

Single, Married, Widowed, or Divorced. (Write the word.) Widowed

6-DATE OF BIRTH. Apr (Month) — (Day) 1894 (Year)

7-AGE. 28 yrs. 9 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Robt Leigh

11-BIRTHPLACE OF FATHER, (State or Country). unknown

12-MAIDEN NAME OF MOTHER. Morgant

13-BIRTHPLACE OF MOTHER, (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Baxter

(Address) 162 East St

15- FILED JAN 15 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jany (Month) 6 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency due to Septicemia — 2 days

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. R. Miller M. D. (Coroner)

1-13 1923 (Address) 516 North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel DATE OF BURIAL, Jan 15 1923

20-UNDERTAKER, John W Henderson & Monument ADDRESS 1302

U. S. Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION should state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

of 2nd hunter, returned. communicated. Inquiry by both cases accident occurred sometime in sept 1922.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, **first**, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage*,	*Meningitis*,	*Phlebitis*,
Cellulitis,	*Gangrene*,	*Miscarriage*,	*Pyemia*,
Childbirth,	*Gastritis*,	*Necrosis*,	*Septicemia*,
Convulsions,	*Erysipelas*,	*Peritonitis*,	*Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to same.

D71155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 ~ D71155

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 203 So. Madeira St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Eugene Trusty

(Residence in Baltimore: No. 203 So. Madeira St.; 49 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: Dec 4 1873 (Month) (Day) (Year)

7-AGE: 49 yrs. 1 mos. 8 ds. If LESS than 1 day, ...hrs. or.....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Wagon Driver
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Wm Trusty

11-BIRTHPLACE OF FATHER, (State or Country): Balto. Md

12-MAIDEN NAME OF MOTHER: Margaret Jacobs

13-BIRTHPLACE OF MOTHER, (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Trusty

(Address) 203 So. Madeira St

15 Filed JAN 15 1923 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 12 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis unknown

(Duration) yrs. mos. ds.

(Signed) H. C. Norton M. D.

(Coroner)

Jan 14 1923 (Address) Curtis Bay, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cause Cemetery DATE OF BURIAL: Jan 15 1923

20-UNDERTAKER: E. Hughes ADDRESS 412 W. Fayette

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. state CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21 M&T 1500 Bks.

D71156

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 D71156

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home + Infirmary 126

CITY OF BALTIMORE: (No. 1st N. Broadway ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Antonia Filou — FILOU

(a) RESIDENCE NO. 529 S. 13th Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Not known — yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Thomas Filou

6 DATE OF BIRTH (month, day, and year) ? ? 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	22	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house mfr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Frank Stamoulas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER ? Rapous

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Thomas Filou

(Address) 529 S. 13th St.

15 JAN 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1922, to Jan 14, 1923, that I last saw him alive on Jan 14, 1923, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Tubo-ovarian Abscess

Gen'l Peritonitis —

(duration) yrs. 3 months mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia three weeks.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known —

Did an operation precede death? Yes Date of Dec 18 1922

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Keith L. Rice M. D.

, 19 (Address) Church Home + Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Jan. 16, 19 23

20 UNDERTAKER H E Hughes — ADDRESS 414 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Gonococcus Infection

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71157

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 106-001

CERTIFICATE OF DEATH.

D71157

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 West 25-12 ½ ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marjorie Harper Wright

(a) RESIDENCE. No. 2 West 25-12 ½ ST., WARD. California

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 25-12 ½ 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) California

PARENTS

10 NAME OF FATHER Harry Harper Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Mary Owen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

11 Informant Harry Harper Wright

(Address) 2-W. 25½ St.

15 JAN 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Jan 15, 1923, that I last saw her alive on Jan 14, 1923, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis
Chronic Malnutrition

(duration) yrs. 8 mos. 20 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Lockard, M. D.

Jan 15 1923 Address) 42 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: 1/15 1923

20 UNDERTAKER: Liston & Russelbaugh

ADDRESS: 2620 St Paul

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71158 HEALTH DEPARTMENT—CITY OF BALTIMORE 45 D71158

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas E. Eaton

(a) RESIDENCE NO. 25 S. Ellwood Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred about 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Eaton

6 DATE OF BIRTH (month, day, and year) Dec 17th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Mr. Eaton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Barbra Bartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Sarah Eaton

(Address) 25 Elwood

Filed JAN 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1922, to Jan. 12, 1923, that I last saw him alive on Jan. 12, 1923, and that death occurred, on the date stated above, at 6:45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 1-4-23

Was there an autopsy? No

What test confirmed diagnosis? P.S. & Laboratory

(Signed) J. V. Jezerbicki, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 1/15 1923

20 UNDERTAKER John A. Inman — ADDRESS 3000 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71159

CERTIFICATE OF DEATH.

90 D71159

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 3 WARD)

2-FULL NAME Joseph Mitchell

(a) RESIDENCE NO. 227 Herrings Court ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): March 17, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	?63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert Co., Maryland

PARENTS

10 NAME OF FATHER: Thomas Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbot Co. Maryland

12 MAIDEN NAME OF MOTHER: Margt. Darke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Talbot Co. Maryland

14 Informant: Municipal Hospital Records. (Address)

15 JAN 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from January 12, 1923, to January 13, 1922, that I last saw him alive on January 13, 1922, and that death occurred, on the date stated above, at 3:15 A.M.

The CAUSE OF DEATH* was as follows:

Head Injuries

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) ? yrs. 9 mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Post mortem

(Signed) [illegible] M. D.

1/13/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leakey Cemetery	Jan. 15 1923
20 UNDERTAKER	ADDRESS
Mrs. Joseph E. Locke	1302 Jefferson St.

D71160

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71160

CERTIFICATE OF DEATH.

94-003

REGISTERED No. C

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 1109 Comet St. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Margaret Elizabeth Harell

(Residence in Baltimore: No. 1109 Comet St. 5th St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, December, 1 (Month) (Day) (Year)

7-AGE, 23 yrs. 1 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Harell

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Hattie Merifield

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. D. Harell

(Address) 1109 Comet

15 JAN 15 1923 ROBERT R. KRAUTER,

Filed....., 191.... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 13, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

Bronchial (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) M. M. Kelly M. D. (Coroner.)

Jan 13, 192... (Address) 1059 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel. DATE OF BURIAL, Jan. 15, 1923

20-UNDERTAKER Mrs. G. F. Lock ADDRESS 1302 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71161

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71161

CERTIFICATE OF DEATH.

47

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 18 WARD)

2-FULL NAME Bella Clark

(a) RESIDENCE NO. 1220 Hollins ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH INK OR INDELIBLE PENCIL. Information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Singleton

6 DATE OF BIRTH (month, day, and year) Feb. 5-1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Miss Lula James
(Address) 565 N Monroe St

15 JAN 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-12-1923

17 I HEREBY CERTIFY, That I attended deceased from Dec-22, 1922, to Jan-12, 1923, that I last saw her alive on Jan-12, 1923, and that death occurred, on the date stated above, at 8.22 P m.

The CAUSE OF DEATH* was as follows:

Inoperable Carcinoma of right Breast.

(duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility (duration) ..... yrs. ..... mos. 20 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Thomas J. Cain, M. D.

1/15, 1923 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	1-15 1923
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun Hollins sts

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71162

CERTIFICATE OF DEATH.

129 D71162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Patapsco ST. 23 WARD)

2-FULL NAME Margaret A Demuth

(a) RESIDENCE NO. 1807 Light ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John E. Demuth

6 DATE OF BIRTH (month, day, and year): Dec 13 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Martin Mockel

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mary Brandmiller

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant: Mr John Demuth

(Address) 1707 Patapsco St

15 JAN 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 12, 1923, to Jan 13, 1923, that I last saw h alive on Jan 12, 1923 and that death occurred, on the date stated above, at 4.40 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of,

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) A. Krauthamm M. D.

1923 (Address) 1 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A & B — DATE OF BURIAL: 1-16 1923

20 UNDERTAKER: E & B Hank — ADDRESS: 115 E Preston

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71163

D71163

CERTIFICATE OF DEATH.

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 Riverside Ave ST., 24 WARD)

2-FULL NAME Jane Wilkins

(a) RESIDENCE NO. 1208 Riverside Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Wilkins

6 DATE OF BIRTH (month, day, and year) Feb 22 Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Samuel Johnson

(Address) 1208 Riverside Ave

15 JAN 15 1923 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923 to Jan 14, 1923

that I last saw h alive on Jan 13, 1923

and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ephemeris

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R.E.K. Campbell, M.D.

Jan 14, 1923 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL 1-16 1923

20 UNDERTAKER E & B Hale ADDRESS 1156 W Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71164

CERTIFICATE OF DEATH.

90 D71164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Saul Begin.

(a) RESIDENCE NO. 102 S. Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? unknown yrs. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54		—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser, 80

(b) General nature of industry, business, or establishment in which employed (or employer) Clothes Presser.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hospital Records

(Address)

15 ROBERT R. KRAUTER, Burial Permit Clerk

FILED JAN 15 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1923, to Jan. 14, 1923.

that I last saw him alive on Jan. 14, 1923,

and that death occurred, on the date stated above, at 11:10 PM

The CAUSE OF DEATH was as follows:

Bronchial Asthma

Mitral Regurgitation

unknown yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

unknown duration yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Signs

(Signed) R. M. Rhodes, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL Jan 15 1923

20 UNDERTAKER May Lemmon ADDRESS 1116 Bolton St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Heinbockel

D71165

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D71165

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N Pine ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. S. Heinbockel.

(a) RESIDENCE NO. 400 N Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Philipina Heinbockel nee Koch.

6 DATE OF BIRTH (month, day, and year): June 10-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs Philipina Heinbockel

(Address) [redacted] St

15 FILED JAN 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 13th 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 19 21 to Jan 15 1923.

that I last saw h in alive on Jan. 19 23

and that death occurred, on the date stated above, at 9 15 P m

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Diabetes

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ellis D Dillocks M. D.

, 19 (Address) 2318 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 1-16 1923

20 UNDERTAKER: Mrs Dorsey [redacted]

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dawson

D71166 HEALTH DEPARTMENT—CITY OF BALTIMORE

199- D71166

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Lola Francis Dawson

(Residence in Baltimore: No. 2137 W. Baltimore St. St.; yrs....., mos....., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Married

6-DATE OF BIRTH: May (Month) 30 (Day) 1900 (Year)

7-AGE: 22 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: James Warren

11-BIRTHPLACE OF FATHER, (State or Country): Del

12-MAIDEN NAME OF MOTHER: Margarte Lee

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Warren

(Address) 2137 W Baltimore St

15- Filed JAN 15 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 13 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

General Septicemia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Self induced abortion

(Duration) ..... yrs. 1 mos. 2 ds.

(Signed) H. T. Grunert M. D. (Coroner.)

1/13 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Jan. 16, 1923
20-UNDERTAKER.	ADDRESS
Geo. J. Smith	1552 Hollins St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

67 Perry Ave New York

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71167

CERTIFICATE OF DEATH.

D71167

15 74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. W. Perry

(a) RESIDENCE No. 2201 Ellamont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1½ yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Manufacturer

(c) Name of employer Diamond Match Co.

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Wm L. Perry

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country) Louisiana

12 MAIDEN NAME OF MOTHER Emma V. Perry

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Chas. W. Perry himself.
(Address)

15 Filed JAN 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1923, to Jan. 14, 1923, that I last saw him alive on Jan. 14, 1923, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 60 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Signs.

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York City	Jan 15 1923
20 UNDERTAKER	ADDRESS
George J. Smith	532 Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Acute Pulmonary Oedema

Spec.—1-10-21—M&T—1500 Bks.

D71168

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 807 (St.) Hayward Ave (Ward) 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ferdinand Stisi

(a) RESIDENCE NO. 807 Hayward Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Stisi

6 DATE OF BIRTH (month, day, and year): July 30-1841

7 AGE — Years: 81 — Months: 5 — Days: 14 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe maker

(b) General nature of industry, business, or establishment in which employed (or employer): retired 10 years.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Godfrey Stisi

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Harry E. Stisi 2326 E. Madison St.

15 JAN 15 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 10 1923, to Jany 13 1923, that I last saw him alive on Jany 13 1923, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Karl G. Sanderlin, M. D.

, 19 (Address) Reisbertown Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan. 16 1923

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 363 Fallo Rd.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Spec.—1-10-21—M&T—1500 Bks.

D71169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D71169

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 930 Woodland Ave St. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett R. Buffington

(a) RESIDENCE NO. 930 Woodland Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Howard C. Buffington

6 DATE OF BIRTH (month, day, and year): Dec 11 1856

7 AGE: Years 66 Months 1 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Maryland

PARENTS

10 NAME OF FATHER: John H. Pare

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Maryland

12 MAIDEN NAME OF MOTHER: Mary E. Bull

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Maryland

14 Informant: Howard C. Buffington

(Address): 930 Woodland Ave

15 Filed JAN 15 1923 ROBERT R. KNAPPLER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 13 1923

17

I HEREBY CERTIFY, That I attended deceased from January 7, 1922, to Jan. 13, 1923, that I last saw h[illegible] alive on Jan. 12, 1923 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Parenchym. Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) F. H. Machen, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Jan. 15 1923

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 363 Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71170

100-001

D71170

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 S. Paca St - ST.: 21 WARD)

2-FULL NAME Leroy John Reese

(a) RESIDENCE. No. 910 S. Paca St - ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Arthur Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mario Noll.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr Arthur Reese.

(Address) 910 S. Paca St.

15 Filed . 19 ROBERT R. KRAUSER, Registrar

JAN 15 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14th 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 . 1923. to Jan 14 . 1923.

that I last saw h. im alive on Jan 14 . 1923.

and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John Estaynbury M. D.

. 19 (Address) 1037 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL Jan. 16th 1923

20 UNDERTAKER E. Gowan Hall ADDRESS

per E. J. Gowan 908 Hollins St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71171

CERTIFICATE OF DEATH.

31 D71171

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 578 N. Bond St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Williams

(Residence in Baltimore: No. ~~5~~ 578 N Bond St.; 50 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Jan 24, 1872 (Month) (Day) (Year)

7-AGE, 50 yrs. 11 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Shipping Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). 309

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John W. Williams

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Earle Williams (Son)

(Address) 578 N. Bond St

15- Filed JAN 15 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 12, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1922, to Jan 1923, that I saw him alive on 1/11 1923, and that death occurred, on the date stated above, at 1A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) unknown

(Duration) yrs. mos. ds.

(Signed) R. E. Young M. D.

1/12, 191.. (Address) 1429 Bolton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery DATE OF BURIAL. Jan 15, 1923

20-UNDERTAKER Byrd Robert & Elliott ADDRESS 1725 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

D71172

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D71172

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 N. Durham ST., 7 WARD)

2-FULL NAME Mary L. Wheatley

(a) RESIDENCE NO. 417 N. Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Wheatley, husband

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years 52, Months —, Days —. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General domestic

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: William Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Nancy Dulls

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mary Dockens

(Address): 417 N Durham St

15 Filed JAN 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1922, to Jan. 14, 1923.

that I last saw her alive on Jan. 14, 1923.

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Gastro-intestinal catarrh

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson, M. D.

1923 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Burst cemetery

DATE OF BURIAL: Jan 17 1923

20 UNDERTAKER: Edward Bryson

ADDRESS 1631 Arlington

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D71173

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71173

CERTIFICATE OF DEATH.

11-002

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Mem. Hosp. St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. Clark Kieffer

(Residence in Baltimore: No. 2804 Chelsea Terrace St.; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: January 24, (Month) (Day) 1874 (Year)

7-AGE: 48 yrs. 6 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Editor
(b) General nature of industry, business, or establishment in which employed (or employer): Balto. Sun

9-BIRTHPLACE, (State or Country): Hagerstown, Md.

PARENTS

10-NAME OF FATHER: J. S. Kieffer

11-BIRTHPLACE OF FATHER, (State or Country): Pa.

12-MAIDEN NAME OF MOTHER: Mary Clark

13-BIRTHPLACE OF MOTHER, (State or Country): Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. D. Kieffer

(Address) 2804 Chelsea Terrace

15- FILED JAN 15 1923 192.. ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 13, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Oedema of lungs.

(Duration) ....yrs. ....mos. 1½ ds.

CONTRIBUTORY (Secondary) Ac. dilatation of heart,

(Duration) ....yrs. ....mos. 1 hr. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Jan 15 1923 (Address) 200 Fremont Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Hagerstown Md. DATE OF BURIAL: 1/16/23

20-UNDERTAKER: H. H. Tabler & Son ADDRESS: Balto. Md.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71174 — CERTIFICATE OF DEATH. — 188-003 D71174

Registered No. C.....

1-PLACE OF DEATH Bromwell ann s

City of BALTIMORE: (No. Johns Hopkins Hosp St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lorita Robinson

(Residence in Baltimore: No. 1100 E Monument St. (yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-Single, Married, Widowed or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Oct (Month) 13 (Day) 1916 (Year)

7-AGE: 6 yrs. 2 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): North Carolina

PARENTS.

10-NAME OF FATHER: Garrod Robinson

11-BIRTHPLACE OF FATHER, (State or Country): N. C.

12-MAIDEN NAME OF MOTHER: — McMillon

13-BIRTHPLACE OF MOTHER, (State or Country): N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Garrod Robinson

(Address) 1100 E Monument

15- JAN 15 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jany (Month) 11 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Run over by Auto truck —
Crushed Chest
Instantly — Date Jany 11, 23

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Walter M. D. (Coroner.)

1-12-1923 (Address) 508 E Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Lowell DATE OF BURIAL: Jan 15 19 23

20-UNDERTAKER: R. C. Goss ADDRESS: 1425 McElderry

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D71175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71175

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH Lot in the rear of 2218 1-004

City of BALTIMORE: (No. Westport Power House st. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel Cornish. (C) 10 yrs. 11 mos. 26 ds.

(Residence in Baltimore: No. 509 Welcome Alley. St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH, January 26th. 1912. (Month) (Day) (Year)

7-AGE, 10 yrs. 11 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. William Cornish. (C)

11-BIRTHPLACE OF FATHER. (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Maria Cornish. (C)

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maria Cornish. (C) mother.

(Address) 509 Welcome Alley.

JAN 15 1923

Filed ..... 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 11th. 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental coal gas Asphyxia from hot ashes.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto K. Reinhardt M. D. (Coroner.)

Jan. 12 192 3. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet	1. 15 192 3

20-UNDERTAKER.	ADDRESS
R. I. Parham	220 N Hanover

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71176

CERTIFICATE OF DEATH.

74-001

D71176

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3723 Falls Road ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara E. Ford.

(a) RESIDENCE NO. 3723 Falls Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Ford.

6 DATE OF BIRTH (month, day, and year) March 11 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	57	10	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. T. Cox.

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country) "

12 MAIDEN NAME OF MOTHER Sarah E. Tracy

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Edward Ford.

(Address) 3723 Falls Road.

15 Filed JAN 15 1923 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1923.

17 I HEREBY CERTIFY That I attended deceased from Jan. 10, 1923, to Jan. 14, 1923.

that I last saw her alive on Jan. 14, 1923

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy 4

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C. F. Campbell M. D.

1-14 1923 (Address) 2701 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden

DATE OF BURIAL 1/17. 1923.

20 UNDERTAKER Unsworth & Son

ADDRESS 3617 Eastern Av.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71177

CERTIFICATE OF DEATH.

D71177

REGISTERED NO. 74-081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 Druid Hill Av ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reverend Harvey Johnson

(a) RESIDENCE. NO. 1923 Druid Hill ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50+ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 4, 1843

7 AGE — Years: 79 — Months: 5 — Days: 8 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Minister

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

018

9 BIRTHPLACE (city or town) (State or country): Alexander Va Jaquaire County

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown.

14 Informant (Address): Courtney D Johnson 1923 Druid Hill Av

15 DATE RECEIVED: JAN 15 1923

ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12 1923

17 I HEREBY CERTIFY, That I attended deceased from January 9, 1923, to January 12, 1923, that I last saw h alive on January 12, 1923, and that death occurred, on the date stated above, at 5.17 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Haematuria

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Jno. A. Wright, M. D.

Jan 12, 1923 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 1/15/1923

20 UNDERTAKER: Samuel L Hawley

ADDRESS: Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71178

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-0D71178

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital ST., 11 WARD)

2-FULL NAME Wm. R. King.

(a) RESIDENCE No. 1205 N. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret S. King

6 DATE OF BIRTH (month, day, and year) Dec 29-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Teacher

(c) Name of employer Poly. Institute

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Margaret S. King (Address) 1205 N. Charles St

15 Filed JAN 15 1923 ROBERT F. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15th, 1922, to Jany 13, 1923, that I last saw h in alive on Jany 12, 1923, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis with Palsy agitans

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Gustav Wortmann, M. D.

, 19 (Address) 605 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	1/16 1923
20 UNDERTAKER	ADDRESS
Chas. P. Evans & Son	1181 W. Mt Royal Ave

N. B.—WHITE PAPER, WITH CRIMSON TINT. All items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71179

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71179

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE—No. Univ. Hospital ST., W WARD)

2-FULL NAME Frank J. Lowman.

(a) RESIDENCE NO. Ellicott City Md WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Lowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Horton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records (Address)

15 Filed JAN 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st 1922 to Jan. 14 1923

that I last saw h[illegible] alive on Jan 14 1923

and that death occurred, on the date stated above, at 6, ... m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Prostatectomy

Retention

(Duration) 4 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

18 Where did disease contracted if not at place of death? home

Did an operation precede death? yes Date of Nov. 4

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Geo Talley M. D.

(Address) Jan 14 1923 Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Cem — DATE OF BURIAL Jan 16 1923

20 UNDERTAKER Easton Sons — ADDRESS Ellicott City

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71180 HEALTH DEPARTMENT—CITY OF BALTIMORE D71180

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 324-E. Pagon ST., 20 WARD)

2-FULL NAME Fannie Gerber

(a) RESIDENCE NO. 324-E. Pagon ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hyman Gerber

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE: Years 64 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: Morris Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Denkers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis (Address): 1439 E Balto St

15 Filed JAN 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 15, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1923. to Jan. 15, 1923.

that I last saw her alive on Jan. 14, 1923.

and that death occurred, on the date stated above, at 12.30 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary): Chronic Myocarditis Angina Pectoris

(duration) 1 yr. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Nathan B Bordenmay M. D.

1/15, 1923. (Address) 211 E Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Hearing Room — DATE OF BURIAL: 1/15 1923

20 UNDERTAKER: Jack Lewis 1439 — ADDRESS: E Balto St

N. B.—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

×90 D71181

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Univ. Hospital ST., 4 WARD)

2-FULL NAME Joshua Sundergill

(a) RESIDENCE NO. Union Bridge, Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Matilda Sundergill

6 DATE OF BIRTH (month, day, and year) Etcetera

7 AGE: Years 86; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Jos. Sundergill

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md.

14 Informant: Hospital Records (Address)

15 JAN 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1 1922 to Jan. 14 1923

that I last saw h[illegible]live on Jan 14 1923

and that death occurred, on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH* was as follows:

Bilateral bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) chronic valvular heart disease - cardiac hypertrophy ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy & lab findings

(Signed) G. Costally M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Unionville Md — DATE OF BURIAL: Jan 17 1922

20 UNDERTAKER: E & B Hale — ADDRESS: 115 E West St Balto

N. B. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71182

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D71182

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1900 Boone St ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S Gorges

(a) RESIDENCE. No. 1900 Boone St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Name of hospital or institution, if any supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Gorges

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U S Government

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Gorges

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Leonora Schumacher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Lillian L Gorges 1900 Boone St

15 Filed JAN 15 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9th, 1923, to Jan 12th, 1923, that I last saw h[e] alive on Jan 12th, 1923, and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) Michael A. Abrams, M. D.

Jan 14 1923 (Address) 360 Cathedral Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Rackey Sons	Jan 16 1923
20 UNDERTAKER	ADDRESS
Cathedral Cem	1377 W Nor[th]

D71183

HEALTH DEPARTMENT—CITY OF BALTIMORE

003

188-

D71183

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE (No. Eastern Ave E 33rd St., St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mrs O. Holmes

(Residence in Baltimore: No. 1312 Eutaw Place, St. 4 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M.	W.	Single

6-DATE OF BIRTH. March (Month) 3 (Day) 1898 (Year)

7-AGE. 24 yrs. 10 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cigarmaker
(b) General nature of industry, business, or establishment in which employed (or employer). Tobacco Co.

9-BIRTHPLACE. (State or Country). Ala.

PARENTS.

10-NAME OF FATHER. J. F. Holmes

11-BIRTHPLACE OF FATHER, (State or Country). Ala

12-MAIDEN NAME OF MOTHER. Lura M. Farrior

13-BIRTHPLACE OF MOTHER, (State or Country). Ala

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. F. Holmes

(Address) 1312 Eutaw Pl

JAN 15 1923 Filed 192

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan (Month) 14 (Day) 1923 (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Accident

Inter Haemorrhage.

Instant

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ....yrs. ....mos. ....ds.

(Signed) Jno Clinton Hobbs (Coroner)

Jan 14 1923 (Address) 1936 Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, State (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Dunnyhaven Ala DATE OF BURIAL. 15 1923

UNDERTAKER. Joseph A Stanley ADDRESS Fulton & Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D71184

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2214 Essex ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Zelinsky

(a) RESIDENCE. No. 2214 Essex ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, O hrs. or 6 min.
0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Boleslav Zelinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ella ~~Zelinsky~~ Dzagmska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Boleslav Zelinsky

(Address) 2214 Essex St

15 JAN 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Jan 15, 1923, that I last saw h[illegible] alive on Jan 15, 1923, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Premature infant

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Swab M. D.

, 19 (Address) 8214 Bell Rd Dk Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL Jan 15 1923

20 UNDERTAKER John M Weber ADDRESS 803 Bank St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71185

CERTIFICATE OF DEATH.

90 D71185

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Chrul

(a) RESIDENCE NO. 240 S. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64-30 yrs. mos. ds. How long in U. S., if of foreign birth 64-30 yrs. mos. ds.

N. B. WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	69	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Victor Chrul

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Municipal Hospital Records. (Address)

15 JAN 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from January 8, 1923, to January 13, 1923, that I last saw him alive on January 12, 1923, and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 8-9 mos ds.

CONTRIBUTORY (Secondary) mitral fibrillation & heart failure

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. A. McKay, M. D.

1/13/ 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross a.a. Co	Jan 16 1923
20 UNDERTAKER	ADDRESS
John A Weber	803 Bank St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71186

CERTIFICATE OF DEATH.

161-001 D71186

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No 2420 Federal St ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Jeff Geller Jr

(a) RESIDENCE. No 2420 E. Federal St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Jan 10 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Andrew Jeff Geller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Wilhelmina F. Siedstrom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Andrew J. Geller Jr
(Address) 2420 E. Federal

15 JAN 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to Jan 14, 1923, that I last saw h[illegible] alive on Jan 14, 1923 and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, both lungs,
6½ months Gestation
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Postmortem Occurred
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

1/15, 1923 (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: 1/15 1923

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated. [illegible]. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71187

CERTIFICATE OF DEATH.

101-001 D71187

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 N. 7th St Brooklyn 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Basil

(a) RESIDENCE NO. 102 N. 7th St Brooklyn 2nd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William A. Basil

6 DATE OF BIRTH (month, day, and year): July 12 1868

7 AGE: Years 54 Months 6 Days —

If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore md

PARENTS

10 NAME OF FATHER: Henry Hockrite

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William A. Basil

(Address): 102 N. 7th St Brooklyn md

15 Filed JAN 15 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1923, to Jan 14, 1923, that I last saw her alive on Jan 13, 1923, and that death occurred, on the date stated above, at 5-30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Health Department

(Signed) William W. Ford M. D.

, 19 (Address) 816 - Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County — DATE OF BURIAL: Jan 16 1923

20 UNDERTAKER: Jos Joerdens Son — ADDRESS: 2178 Pen

N. B. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71188 (Buchta) ✓ 90 D71188

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Aged Men's Home (St.) 19 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frey. Buchta

(a) RESIDENCE. No. 1400 Washington St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? [illegible] yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Charlotte Buchta.

6 DATE OF BIRTH (month, day, and year) July 27 1834

7 AGE: Years 88 | Months 5 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): 606
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Buchta

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Miss. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Jno F Buchta
(Address) 1718 Oliver St

15 Filed JAN 15 1923, 19 ROBERT N. KRAUL Jr. Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 13, 1923, that I last saw h... alive on Jan 13, 1923, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Decay

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Jan 31 1923 (Address) 739 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Jan. 16 1923

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71189

CERTIFICATE OF DEATH.

145 - D71189

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Marie P. Griffith

(a) RESIDENCE NO. 1941 E Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 1 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of John J. Griffel

6 DATE OF BIRTH (month, day, and year) Nov. 26 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	29	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Butterfoss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Josephine P. Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr John J. Griffel

(Address) 1941 E Biddle

JAN 15 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1923, to Jan. 14, 1923

that I last saw her alive on Jan. 14, 1923

and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pertonitis

(duration) yrs. mos. ds.

(over)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. N. Freeman, M. D.

19 (Address) 2631 Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Jan 17 1923

20 UNDERTAKER Henry Woerl's Son — ADDRESS 1301 E Eager St

matter should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

(Child Birth)

Spec.—1-10-21—M&T—1500 Bks.

D71190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D71190

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph N. Jackson

(a) RESIDENCE NO. 3434 Belvidere ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widower of Jane S. Jackson

6 DATE OF BIRTH (month, day, and year): Mar 25 1839

7 AGE: Years 83 Months 9 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ind

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ind.

14 Informant: Rebecca H. Gantz

(Address) 3924 Rebecca Ave West Arlington

15 JAN 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14-1923

17 I HEREBY CERTIFY, That I attended deceased from 10-16-, 1922, to 1-14-, 1923,

that I last saw him alive on 1-14-, 1923,

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of heart

Chr. nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cirrhosis of liver

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at St. Joseph's Hosp ?

Did an operation precede death? Yes Date of 1-8-23 7.A.M.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Newton J. Pearce, M. D.

1/14/1923 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Jan 16 1923

20 UNDERTAKER: Josiah Syfer — ADDRESS: 1004 N. Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71191

D71191

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4011 Roland ave ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick E. Costello

(a) RESIDENCE NO. 4011 Roland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Agnes C. Costello

6 DATE OF BIRTH (month, day, and year) Mch 14-1849

7 AGE: Years 73 | Months 9 | Days 29 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer): none

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick Costello

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Clary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs Bessie Costello 4011 Roland ave

15 Filed 1 15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1 1922 to Jany 13 1923, that I last saw him alive on Jany 13 1923, and that death occurred, on the date stated above, at 12.45 P.M.

The CAUSE OF DEATH* was as follows:

Hypertrophy & Enlarged heart with arterial Sclerosis

about (duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis

about (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) W. J. Costello, M. D.

, 19 (Address) 335 E. 31st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: 1/16 1923

20 UNDERTAKER: John C. Ingram

ADDRESS: 3040 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71192

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 Fair Oaks Ave. WARD 7)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Flood

(a) RESIDENCE NO. 101 Fair Oaks Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John F. Flood

6 DATE OF BIRTH (month, day, and year): Feb. 7, 1865

7 AGE — Years: 57 — Months: 11 — Days: 5 — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Michael McMahon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs. Elin Toolan 101 Fair Oaks Ave

15 Filed 1/15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 12 1923

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1922, to Jany 12, 1923, that I last saw her alive on Jany 10, 1923, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Gastric Carcinoma (duration) 1 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

1/14 1923 (Address) Hamilton Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL 1/16 1923

20 UNDERTAKER: Margaret D. Flynn — ADDRESS 422 Light St

151923

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 3-10-21 M&T 1500 Bks.

D71193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D71193

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 Augusta Ave. ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Holton Healy

(a) RESIDENCE NO. 202 Augusta Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 28" 1922

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER James P. Healy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Cooney

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant James P. Healy (Address) 202 Augusta Ave.

15 Robert P. Harrison, Registrar

JAN 15 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14" 19 23

17

I HEREBY CERTIFY, That I attended deceased from January 10th, 1923, to January 14th, 1923, that I last saw him alive on January 14th, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) Exhaustion & Cyanosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. Gus Macgill, M. D.

1/15 19 23 (Address) Frederick Ave. Catonsville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 1923

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 N. Bells St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71194 HEALTH DEPARTMENT—CITY OF BALTIMORE D71194

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Mallonee

(a) RESIDENCE NO. 307 N. Fremont Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 11 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced ~~HUSBAND of~~ Mary Mallonee

6 DATE OF BIRTH (month, day, and year) Jan. 20, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marketman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

045

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Lewis Mallonee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Tuttle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J. Tuttle

(Address) 959 W Lexington st

N 15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13 1923

17

I HEREBY CERTIFY, That I attended deceased from 12/17, 1922, to 1/13, 1923.

that I last saw him alive on 1/13, 1923,

and that death occurred, on the date stated above, at 5.51 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos 31 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Milton L. Lang, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters — DATE OF BURIAL Jan 16 1923

20 UNDERTAKER John J. Fields — ADDRESS 1200 N Fremont

IMPORTANT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D71195

CERTIFICATE OF DEATH.

101-001

D71195

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1205 Druid Hill Av ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Smith

(a) RESIDENCE. NO. 1205 Druid Hill Av ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Smith

6 DATE OF BIRTH (month, day, and year) Mar 6-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs Morris Whitridge

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John T. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret E. Smith

(Address) 1205 Druid Hill Ave

15 Filed Robert P. Harrison, Registrar

N 15 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1923, to Jan. 14, 1923, that I last saw him alive on Jan. 14, 1923, and that death occurred, on the date stated above, at 12 10 p'm.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Wheatley, M. D.

1/14 1923 (Address) 1236 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int D Auburn Cem	1-17 1923

20 UNDERTAKER	ADDRESS
George H. Holland	1631 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D71196

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71196

71-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST., 17 (9) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geneva Brown

(a) RESIDENCE NO. 508 Pennsylvania Ave ST., City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (HUSBAND) of (or) (WIFE) of: Charlie & Sophie Brown.

6 DATE OF BIRTH (month, day, and year): March 30, 1922

7 AGE: Years 0, Months 9, Days 15. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: Charlie Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): (") Md.

12 MAIDEN NAME OF MOTHER: Sophie Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): (") Va

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records

15 Filed , 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

1 15 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1923, to Jan. 14, 1923, that I last saw her alive on Jan 14, 1923, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis, Pneumococcus

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 1/16 1923

20 UNDERTAKER: Samuel Howard

ADDRESS 578 N Bdle

2. BE WRITTEN PLAINLY, with ordinary pen and ink. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D71197

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71197

CERTIFICATE OF DEATH.

167

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3408 Forest Park Av. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Annie B. Frederick

(Residence in Baltimore: No. 2024 E. Fairmount Av. St.; yrs., 46 mos. 11 ds. 10)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Feb. 3 (Month) (Day) 1876 (Year)

7-AGE. 46 yrs. 11 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Adolphus Frederick

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary Mullikan

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Carlisle

(Address) 409 Chatsworth Av.

15- Robert P. Harrison,

JAN 15 1923 192.... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 13 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gas inhalation
(Illuminating gas)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

Jan. 14, 1923 (Address) 2803 Edmondson Av.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park. DATE OF BURIAL, JAN 16 1923 19....

20-UNDERTAKER, Geo W. Little. ADDRESS 2700 Edmondson Ave.

N 15 1923

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

in mouth, + covered head
with towel. J. F. Hennessy.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D71198 . HEALTH DEPARTMENT—CITY OF BALTIMORE D71198

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2006 Eutaw Place ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia A Bowers

(a) RESIDENCE. No. 2006 Eutaw Place ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Frank K Bowers

6 DATE OF BIRTH (month, day, and year) Jan 9 1868

7 AGE: Years 55 | Months — | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Frank K Bowers

(Address) 2006 Eutaw Place

15 JAN 15 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 15 1923

17 I HEREBY CERTIFY, That I attended deceased from July, 1922, to Jan 15, 1923, that I last saw h[illegible] alive on Jan 15, 1923, and that death occurred, on the date stated above, at 10 40 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina pectoris.

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Frederick Lentz, M. D.

JAN 15 1923, 19 (Address) 2040 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Greenmount — DATE OF BURIAL JAN 17 1923

20 UNDERTAKER Geo W Little — ADDRESS 2700 EDMONDSON AVE

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Blake)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71199

CERTIFICATE OF DEATH.

11-001 D71199

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 Wbstcoat St.; 16 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victoria Blake

(Residence in Baltimore: No. 1024 Wbstcoat St.; 12 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, Unknown (Month), ... (Day), 1870 (Year)

7-AGE, 42 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country): Calvert Co. Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Ringgold

(Address) 1463 N. Carey St

15- Filed ..., 191... Registrar.

Robert P. Harrison,

Burial Permit Blank

JAN 15 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 13, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/10 1923, to 1/13 1923, that I saw h-- alive on Jan 13 1923, and that death occurred, on the date stated above, at 9:15 p.m.

The CAUSE OF DEATH* was as follows:

Influenza and

Acute Congestion of Lungs

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) B. M. Cutter M. D.

1/15, 1923 (Address) 2139 E. H. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Calvert Co.

DATE OF BURIAL, Jan. 16, 1923

20-UNDERTAKER Edward Ringgold

ADDRESS 1463 N. Carey

13.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS [illegible] state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D71200

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71200

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3124 Stafford St., 20 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman G Krell

(a) RESIDENCE No. 3124 Stafford St. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? life yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widower of Jennie Krell

6 DATE OF BIRTH (month, day, and year): May 17 1854

7 AGE: Years 68 Months 7 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Casper Krell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles H. Krell Jr

(Address): 3124 Stafford St

15 Filed ..... 19 ..... Burial Permit Clerk. Registrar

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922, to Jany 12, 1923,

that I last saw h[illegible] alive on Jany 12, 1923,

and that death occurred, on the date stated above, at 4.20 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) W B Hale, M. D.

, 19 (Address) Halethorp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan 16 1923

20 UNDERTAKER: William Cook & Sons — ADDRESS: E Balto

N. B.—WRITE PLAINLY, WITH PENCIL OR INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D71201

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71201

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 623 Cumberland ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Katherine Kehl

(a) RESIDENCE. No. 623 Cumberland ST., WARD.

(Usual place of abode) about 40 years (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female / Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow Henry G Kehl

6 DATE OF BIRTH (month, day, and year): June 8 1879

7 AGE: Years 43, Months 11, Days, If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Westminster Md

PARENTS

10 NAME OF FATHER: Franklin P Malehan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Westminster Md

12 MAIDEN NAME OF MOTHER: Martha Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Westminster Md

14 Informant (Address): Thelma E Kehl 623 Cumberland St

15 Filed: Jan 15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22 - 1922, to Jan 14 - 1923.

that I last saw her alive on Jan 14 - 1923,

and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

about two years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis (duration) 2 or 4 weeks yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phone and (T.B. ?)

(Signed) Carlton M Cook, M. D.

, 19 (Address) Carlton M Cook

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Jan 17 1923

20 UNDERTAKER: William Cahoon & Nathan — ADDRESS

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 1223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71202

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Provident Hospital ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Sayers

(a) RESIDENCE NO. 825 Newington Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 22, 1860

7 AGE: Years 62 Months Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Emma Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Dr. C. E. Jagers 825 Newington Ave

15 Robert F. Duffy, M.D., Registrar

Burial Permit Clerk.

JAN 15 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1922 to Jan 14, 1923.

that I last saw her alive on Jan 14, 1923.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Diabetes, Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Uremia, Coma

Failure (duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. E. Jagers, M. D.

, 19 (Address) 825 Newington Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Jan 16 1923

UNDERTAKER: William Lee

ADDRESS: 660 E Balto

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

160909.
D71203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D71203

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 26 WARD)

2-FULL NAME Joseph Ott.

(a) RESIDENCE No. 112 S. 3rd St. City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Emma Ott. (Wife).

6 DATE OF BIRTH (month, day, and year) ? " "

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56.	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Work.

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Ott.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maggie ? "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1923 to Jan 14, 1923, that I last saw him alive on Jan 14, 1923, and that death occurred, on the date stated above, at 8.00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Chas. R. Bagg M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn DATE OF BURIAL Jan 18 1923

20 UNDERTAKER William Lack ADDRESS 5526 Nath Av

JAN 15 1923

R.—WRITE PLAINLY, WITH UNFADING INK. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71204 HEALTH DEPARTMENT—CITY OF BALTIMORE D71204

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1546 Latrobe Park Terrace St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Walters.

(Residence in Baltimore: No. 1546 Latrobe Park Terrace St.; yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female.	White.	Married.

6-DATE OF BIRTH. October 23rd. 1884. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
38 yrs. 2 mos. 22 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Germany.

PARENTS.

10-NAME OF FATHER. Albert Grenzeman.

11-BIRTHPLACE OF FATHER, (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Matilda Udhart.

13-BIRTHPLACE OF MOTHER, (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Niemann. (sister)

(Address) 1546 Latrobe Park Terrace

15- Robert P. Harrison, 192

Burial Permit Clerk. Registrar.

JAN 15 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 14th. 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto K. Reinhardt (Coroner)

Jany 14. 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Woodlawn ~~Loudon Park~~ DATE OF BURIAL. Jan 16 1923

20-UNDERTAKER, Wm Cook ADDRESS 504 E. Fay

(2)—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71205

CERTIFICATE OF DEATH. 118-002

D71205

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 13 WARD)

2-FULL NAME Mrs. Elizabeth Stern

(a) RESIDENCE NO. 706 N. Hartle Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of A. C. Stern.

6 DATE OF BIRTH (month, day, and year) [redacted] 1872.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER Frederick Bergmann.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER E. Bertrie.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant A. C. Stern (Address) 706 N. Hartle Ave.

15 Filed Jan 15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/15 1923.

17 I HEREBY CERTIFY, That I attended deceased from 1/10, 1923, to 1/15, 1923, that I last saw h[illegible] alive on 1/15, 1923, and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mesenteric thrombosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 1/10/23.

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) J. Miller Guyton, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Reedysville Md	Jan 17 1923
UNDERTAKER	ADDRESS
William Cahoon & Nathan	

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE, ENTERED AS A PERMANENT RECORD, SHOULD CONTAIN every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

15 1923

D71206

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71206

CERTIFICATE OF DEATH.

167

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 946 Hartford Ave St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. James M Colford

(Residence in Baltimore: No. 946 Hartford Ave St., Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH. Dec 26 1871
(Month) (Day) (Year)

7-AGE. 51 yrs. mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired Wagon
(b) General nature of industry, business, or establishment in which employed (or employer). Govt City & Bal

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Patrick Colford

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Ellen Moore

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Mitchell (Sister)

(Address) 946 Hartford Ave

15-

Filed JAN 15 1923 192

Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 14 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Gas Asphyxiation

Possible Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Unknown

2 Hours 1 Accident (Duration) yrs. mos. ds.

(Signed) J. S. H. Patterson M. D.
(Coroner.)

1-15 1923 (Address) 1086 North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral DATE OF BURIAL. Jan 18 1923

20-UNDERTAKER. Elmer M Conklin ADDRESS 324 E Fayette St.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71207

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71207

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH St Agnes Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Agnes McClintock

(a) RESIDENCE NO. 910 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry McClintock

6 DATE OF BIRTH (month, day, and year) Sept 24, 1886.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife-Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Welch

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Dowdle

13 BIRTHPLACE OF MOTHER (city or town) Ireland.
(State or country)

14 Informant Mrs Charles T. Welch

(Address) 910 E Eager St

15 Filed , 19 Robert F. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/13, 1923, to 1/13, 1923, that I last saw h alive on 1/13, 1923, and that death occurred, on the date stated above, at 9.00 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Valvular Disease (Aortic & Mitral insufficiencies)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Moses Paulson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

New Cathedral Cemetery Jan. 17 1923

20 UNDERTAKER — ADDRESS

Elmer W Conklin 524 E Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

15 1923

Spec.—8-24-14—M. & T.—2000 Bks.

D71208 HEALTH DEPARTMENT—CITY OF BALTIMORE D71208

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH REGISTERED No. C .....

CITY OF BALTIMORE: (No. Cheswolde Mt Washington St.; 27th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Bast

(Residence in Baltimore (No. Cheswolde, Mt Washington St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Mar (Month) 6 (Day), 1854 (Year)

7-AGE, 68 yrs. 10 mos. 9 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 321

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Solomon Benj. Bast

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Louisa Bast

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. L. Bast

(Address) 2741 Kings Ave

15. Filed JAN 15 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 14 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1923, to Jan 14 1923, that I saw him alive on Jan 14 1923, and that death occurred, on the date stated above, at 9.05 p m.

The CAUSE OF DEATH* was as follows:

..... Cancer of pancreas .....

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Grippe

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Thomas L. Flood M. D.

Jan 15, 1923 (Address) 735 N Bolton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, 1/17, 1923

20-UNDERTAKER Geo J. Smith — ADDRESS 1532 Hollins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71209

CERTIFICATE OF DEATH.

44 D71209

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 W. Lexington ST.; 18 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lydia Turbin

(Residence in Baltimore: No. 1002 W. Lexington St.; 52 yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feb. (Month) ..... (Day), 1870 (Year)

7-AGE, 52 yrs. 10 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Clark

(Address) 1002 W. Lexington St

15-

Filed JAN 15 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 14 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 25 1922, to Jan 14 1923, that I saw her alive on January 12 1923, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

(a) .....

Carcinoma Liver

.....

.....

(Duration) about 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) about 2 yrs. ..... mos. ..... ds.

(Signed) M. O'Sullivan Stovall M. D.

Jan 15, 1923. (Address) 636 W. Lombard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem

DATE OF BURIAL, Jan 17, 1923

20-UNDERTAKER Chas. J. Smith

ADDRESS 153 Hollins St

Spec.—1-10-21—M&T—1500 Bks.

D71210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D71210

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Mercy Hospital St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frau Tolodzieckie

(a) RESIDENCE NO. 6th & Wallace St. Fairfield Md. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Alex Tolodzieckie

6 DATE OF BIRTH (month, day, and year): July, 14 1888.

7 AGE: Years 34. Months 5 Days 27. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penny, Russia

PARENTS

10 NAME OF FATHER: John Tolodzieckie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Minnie Stubowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Hospt Record (Address): Mercy Hospt

15 Filed JAN 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923 to Jan. 14, 1923.

That I last saw her alive on Jan 13, 1923.

and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

Cachexia

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchitis Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. D. Vasapera M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. DATE OF BURIAL: 1/18/23 19

20 UNDERTAKER: Geo. A. Fuller & Sons ADDRESS: Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Archibald F. Rader)

D71211

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 49

D71211

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Archibald F. Rader

(a) RESIDENCE NO. Charleston, W. Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Aug. 8, 1848

7 AGE — Years: 074. Months: 5 Days: 7. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): W. Va.

PARENTS

10 NAME OF FATHER: S. Rader

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Elizabeth Perkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va.

14 Informant: Mrs. Rader

(Address) Mercy Hospital

15 Filed JAN 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4. 1922 to Jan. 15. 1923.

that I last saw h[illegible] alive on Jan. 1[illegible] 1923.

and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Sarcoma Rt. Leg X Ray

Shrader

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Atherosclerosis

(duration) 1. yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path. & Signs

(Signed) W. D. Straughn M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 1/17/23

20 UNDERTAKER: Lovell Finley Fulton & Gazette

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71212

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00

D71212

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 854 (ST.,) St Paul (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas A Wilbur

(a) RESIDENCE No. 854 St Peter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 13 1922

7 AGE — Years: — Months: 3 Days: 10 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Harry C Wilbur

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Minnie E. Wurster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Harry C Wilbur 854 St Peter st

15 JAN 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 19 23

I HEREBY CERTIFY That I attended deceased from Jan 10. 1923 to Jan 14. 1923.

that I last saw him alive on Jan 14. 1923

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) avrl

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ... M. D.

19 (Address) 11 New Church St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park James Deyman & Son

DATE OF BURIAL: 1-16 1923

20 ~~UNDERTAKER~~ Cemetery: Baltimore Cemetery

ADDRESS: 1000 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Housler

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71213

CERTIFICATE OF DEATH.

51 D71213

1-PLACE OF DEATH Bayview Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 9 WARD)

2-FULL NAME Johanna Housler

(a) RESIDENCE NO. 735 Harford ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed JAN 16 1923 ROBERT R. KRAUTER, Registrar

JAN 16 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/13/23

17 I HEREBY CERTIFY, That I attended deceased from 1/13/23, 19..., to 1/13/23, 19...,

that I last saw her alive on 1/13/23, 19...,

and that death occurred, on the date stated above, at 9 00 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. C. McKay, M. D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Jan. 18 1923

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Harford ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT IS PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122-001

D71214

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp ST., 11 WARD)

2-FULL NAME William J. Thompson

(a) RESIDENCE NO. 1305 Fendeller ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 ~~Single~~, ~~Married~~, Widowed, or Divorced. (write the word): Widowed

5a If ~~married~~, widowed, or ~~divorced~~
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1848

7 AGE — Years: 74 — Months: 8 — Days: — If LESS than 1 day, hrs. or ..... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Gustavus A. Thompson

11 BIRTHPLACE OF FATHER (city or town) Queen Anns
(State or country) Co Md

12 MAIDEN NAME OF MOTHER Marie Bolorse

13 BIRTHPLACE OF MOTHER (city or town) Princton
(State or country) N J

14 Informant Miss M. Powell
(Address) 1305 Fendeller Ave

15 Filed JAN 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1923, to Jan. 14, 1923, that I last saw him alive on Jan. 14, 1923, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis of Liver

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Gastric Hemorrhages

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & E.

(Signed) J. V. Szczerbicki, M. D.

19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Jan 17 1923

20 UNDERTAKER: Henry H. Jenkins & Sons Co — ADDRESS: Eastland Ave & Bethel

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71215

CERTIFICATE OF DEATH.

90

REGISTERED NO. D71215

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 S Chester ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C Seward

(a) RESIDENCE. No. 19 S Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Seward

6 DATE OF BIRTH (month, day, and year) October 30 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER James Seward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Eliza Seward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Mary Seward
(Address) 19 S Chester St

15 JAN 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1922, to Jan. 11, 1923, that I last saw him alive on Jan. 11, 1923, and that death occurred, on the date stated above, at 7:30 ~~A~~ P. m.

The CAUSE OF DEATH* was as follows:

Mitral Heart disease

(duration) — yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edwin B. Feaby, M. D.

1/16 1923 Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mound	Jan 17 1923
20 UNDERTAKER	ADDRESS
Kendall Dyffel & Son	37 S ...

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71216

100-001 D71216

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 N Glover ST., 6 WARD)

2-FULL NAME Henry Joseph Kraus

(a) RESIDENCE NO. 404 N Glover ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) December 20 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER Frederick J Kraus

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Amanda Schaaf

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country)

14 Informant Frederick A Kraus
(Address) 404 N Glover

15 JAN 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 15 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/11, 1923, to 1/15, 1923,
that I last saw him alive on 1/15, 1923,
and that death occurred, on the date stated above, at 1:45 a. m.

The CAUSE OF DEATH* was as follows:

Broncho. pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) DUH
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Dr. Dawden, M. D.

1/15, 1923 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 16 1923

20 UNDERTAKER Randall Funeral Home — ADDRESS 847 N

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21 M&T 1500 Blks.

D71217

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D71217

CERTIFICATE OF DEATH

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO. .....

CITY OF BALTIMORE: (No. Broadway Infirmary WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida E. Jones

(a) RESIDENCE NO. 1516 Bolton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 30 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER Edward Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co.

12 MAIDEN NAME OF MOTHER Maria Cissell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant Arthur L. Jones
(Address) 1516 Bolton St.

15 Rec'd JAN 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1923, to Jan 15, 1923, that I last saw h[illegible] alive on Jan 15, 1923, and that death occurred, on the date stated above, at 9:03 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical Methods

(Signed) Richard S. Corbett, M. D.

, 19 (Address) C W D

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan. 16 1923

20 UNDERTAKER John O. Mitchell ADDRESS 120 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Offley.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71218

CERTIFICATE OF DEATH.

1-24-00 D71218

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2003 Bolton St.; ward 14)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha M. Offley

(Residence in Baltimore: No. 2003 Bolton St.; 70 yrs., 2 mos. 15 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	S

6-DATE OF BIRTH, Oct. (Month) 28 (Day) 1852 (Year)

7-AGE,	If LESS than 1 day,
70 yrs. 2 mos. 15 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): 68

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Michael Offley

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Martha Edmonds

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jackson W. Mashin

(Address) Havre de Grace Md

15- JAN 16 1923 Filed....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 13 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 3 1923, to Jan 13 1923, that I saw her alive on Jan 13 1923, and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) .....yrs. .....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) O O Lloyd M. D.

Jan 14, 1923 (Address) 2232 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. 5 mos. .....ds. In the State 70 yrs. 2 mos. 15 ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Havre de Grace

19-PLACE OF BURIAL OR REMOVAL, Friends Cemetery

DATE OF BURIAL, Jan 16, 1923

20-UNDERTAKER Jno. C. Mitchell

ADDRESS 1202 W. Fayette St.

D71219

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71219

CERTIFICATE OF DEATH.

2374-00

1-PLACE OF DEATH

City of BALTIMORE: (No. 55 W. West St. St., ... Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Ford. (C)

(Residence in Baltimore: No. 55 W. West St. St.; yrs. 47 mos. 8 ds. 3)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored.	Married.

6-DATE OF BIRTH. May 11th. 1875. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
47 yrs. 8 mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): D W D

9-BIRTHPLACE, (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Hall. (C) wife.

(Address) 55 W. West St.

15-Filed JAN 16 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 14th. 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt (Coroner)

Jan. 14 1923 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Jan 17 1923

20-UNDERTAKER. A. E. Brown & Son ADDRESS 1011 W. Ward

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71220

CERTIFICATE OF DEATH

STILLBIRTH No. 1 D71220

REGISTERED NO. 12009

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Oak ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby McClymont

(a) RESIDENCE. NO. 2204 Oak ST.. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Twins

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of "

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or 10 min.
Twins			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md.
(State or country)

PARENTS

10 NAME OF FATHER Arthur McClymont

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Oak Ridge, N.J.

12 MAIDEN NAME OF MOTHER Sarah Guild

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Troy, Pa.

14 Informant Arthur McClymont
(Address) 2204 Oak St.

15 Filed JAN 16 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 19 23

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....,

that I last saw h..... alive on....., 19.....,

and that death occurred, on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows:

Prematurity
(6 mo. Pregnancy)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Martin, M. D.

. 19 (Address) 4037 Falls Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER Commissioner Health.	ADDRESS

JAN 13 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71221 HEALTH DEPARTMENT—CITY OF BALTIMORE D71221

CERTIFICATE OF DEATH.

Registered No. C 2774-00

1-PLACE OF DEATH

City of BALTIMORE: (No. Biddison Lane, Raspberry St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles J. Neumeister

(Residence in Baltimore: No. Biddison Lane Raspberry St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: March 23 1867 (Month) (Day) (Year)

7-AGE: 55 yrs. 9 mos. 20 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Guard
(b) General nature of industry, business, or establishment in which employed (or employer): City Jail

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS:

10-NAME OF FATHER, Karl Neumeister

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Neumeister

(Address) Biddison Lane

15- JAN 16 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 13 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. H. Dallas M. D. (Coroner.)

1-16 1923 (Address) 508 6 North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery — DATE OF BURIAL, Jan. 16 1923

20-UNDERTAKER, Fredk Lassahn & Sons — ADDRESS, Fullerton

Spec.—6-3-19—H. P. Co.—1000 Bks.

D71222 HEALTH DEPARTMENT—CITY OF BALTIMORE D71222

CERTIFICATE OF DEATH. 66

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 106 N. Bruce ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Collins

(a) RESIDENCE. No. 106 N Bruce ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Collins

6 DATE OF BIRTH (month, day, and year) July 6, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 310

(b) General nature of industry, business, or establishment in which employed (or employer) Junk Shop.

(c) Name of employer Newton Iron and Metal Co. Baltimore,

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Henry Collins

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore,

14 Informant Anna Collins (Address) 106 N Bruce St

15 Filed JAN 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 15 1923

17 I HEREBY CERTIFY, That I attended deceased from January 11, 1923, to Jan 15, 1923, that I last saw him alive on Jan 13, 1923, and that death occurred, on the date stated above, at 9.40 A m.

The CAUSE OF DEATH* was as follows:

Hemoptysis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism. Dementia (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H. Wright, M. D.

(Address) 120 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 17 1923
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71223

CERTIFICATE OF DEATH.

31 D71223

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Posey

(a) RESIDENCE NO. 4160½ Biddle st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M.T.H.

15 JAN 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1922, to Jan. 14, 1923,

that I last saw her alive on Jan. 14, 1923,

and that death occurred, on the date stated above, at 3.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Reuben L. Pendleton M. D.

1-15-23, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL Jan 1, 1923

20 UNDERTAKER Hamil Easter

ADDRESS 916 Park ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71224

CERTIFICATE OF DEATH.

129 D71224

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 S. Highland Avenue, 16 WARD)

2-FULL NAME Jacob Lang

(a) RESIDENCE No. 12 S. Highland Avenue, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Lang.

6 DATE OF BIRTH (month, day, and year) Jan 12 - 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 609

(b) General nature of industry, business, or establishment in which employed (or employer) (Clerk for P. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Lang.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Conrad Lang. (Address) 208 N. 3rd St.

15 Filed JAN 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922, to Jan 14th, 1923, that I last saw h[illegible] alive on Jan 13th, 1923, and that death occurred, on the date stated above, at 3 40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Greene, M. D.

Jan 14 1923 (Address) 1402 Eastern Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st Evangelical Luth.	Jan 17 1923
20 UNDERTAKER	ADDRESS
H. Lander Sons	1700 Park

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71225

CERTIFICATE OF DEATH.

46 D71225

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 N. Lakewood Ave ST., 1 WARD)

2-FULL NAME Verona Baumgarten

(a) RESIDENCE NO. 522 N. Lakewood Ave, ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Baumgarten

6 DATE OF BIRTH (month, day, and year): Jan 13 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitress

(b) General nature of industry, business, or establishment in which employed (or employer): Fidelity

(c) Name of employer: Trust Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Adam Diegel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Schmittler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William P. Zimmerman

(Address): 522 N Lakewood ave

15 JAN 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1922, to Jan 15, 1922, that I last saw h[illegible] alive on Jan 14, 1923 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) E. H. Meyer M. D.

1/15, 1923 (Address) 2638 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: Jan 18 1923

20 UNDERTAKER: H. Sander Sons

ADDRESS: 1210 Eastern Ave

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71226

CERTIFICATE OF DEATH.

89 D71226

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 813 N Patterson Park Ave ST., 7 WARD)

2-FULL NAME Julius L. Reibetanz

(a) RESIDENCE NO. 813 N Patterson Park Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lendina Reibetanz

6 DATE OF BIRTH (month, day, and year) Feb. 11, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Dr. Karl Reibetanz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Lendina Reibetanz (Address) 813 N. Patterson Park Ave.

15 Filed JAN 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1923, to Jan 14th, 1923, that I last saw him alive on Jan 10th, 1923, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. 1 mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? No Date of "

Was there an autopsy? "

What test confirmed diagnosis? Physical Exam + c

(Signed) Clarence Stone, M. D.

, 19 (Address) 40 E. 25 St. 21.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Jan 18 1923

20 UNDERTAKER H. Sander Sons — ADDRESS 1710 Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71227

CERTIFICATE OF DEATH.

D71227

REGISTERED NO. 6

1-PLACE OF DEATH Bayview Hospital 73

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Green

(a) RESIDENCE NO. 122 Druid Hill Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single (?)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Thomas Green

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Hospital Records
(Address)

15 Date received JAN 16 1923 ROBERT P. KRAUSE Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/14/23 19

17 I HEREBY CERTIFY, That I attended deceased from 5/16/22, 19..... to 1/14/23, 19.....

that I last saw him alive on 1/14/23, 19.....

and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Primary Lateral Sclerosis

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. G. McKay, M. D.

1-15-1923 Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 6 1923
20 UNDERTAKER	ADDRESS
Wm P. Case & Son	1400 Madison

Spec.—5-19-13—M. & T.—500 Bks.

D 71228 Linsey 46 D 71228

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4424 St Georges ST.; Grans 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agness Linsey

(Residence in Baltimore: No. 4424 St. George ave St.; Life yrs., mos. ds)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colrd

5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 21, 1884 (Month) (Day) (Year)

7-AGE, 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): House Wife 37

9-BIRTHPLACE, (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Robert Garrett

11-BIRTHPLACE OF FATHER (State or Country), Baltimore County

12-MAIDEN NAME OF MOTHER Jane Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Balt Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. Fasth. Robert Garrett

(Address) 4424 St Georges Ave

15- Filed JAN 16 1923, 191 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 13, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 21 1922, to Jan 13 1923, that I saw h[illegible] alive on Jan 5 1923 and that death occurred, on the date stated above, at 1235 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Metastasis in lungs

(Duration) 1 yrs. 6 mos. ds.

(Signed) G. W. Bastl M. D.

Jan 15, 1923 (Address) 522 Sheridan Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Fair Ce. Forest Sta. DATE OF BURIAL, Jan 16, 1923

20-UNDERTAKER Mrs Robert A Elliott ADDRESS 725 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

D71229

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D71229

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 E. Pleasant ST., 4 WARD)

2-FULL NAME Ella Jones

(a) RESIDENCE NO. 104 E. Pleasant ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1½ yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Benj. Jones

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Charles Pinckney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Harriet Hemsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Benj. Jones 104 E. Pleasant St

15 JAN 16 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1923, to Jan. 14, 1923, that I last saw h[illegible] alive on Jan. 14, 1923, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. 3 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jacob Lobein M.D.

(Address) 1328 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Jan 18 1923

20 UNDERTAKER: Mrs R A Elliott — ADDRESS: 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71230 HEALTH DEPARTMENT—CITY OF BALTIMORE D71230

CERTIFICATE OF DEATH. + 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Harford Rd & Altona Ave WARD 27)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Baldwin Green

(a) RESIDENCE. NO. Harford Rd & Altona Ave ST., WARD. Long Green - Balto Co Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S., if of foreign birth? 68 yrs. 11 mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~WIFE of~~ wife of John S. Green

6 DATE OF BIRTH (month, day, and year) January - 1854

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	68	11	— ?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Morris Baldwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Hanway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Eleanor L. Green

(Address) Long Green md

15 JAN 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 15, 1923, to Jany 15, 1923, that I last saw her alive on Jany 15, 1923, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

5 Minutes

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Morris B. Green, M. D.

1/15, 1923 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sweet Air - Balto. Md

DATE OF BURIAL Jan - 18 - 1923

20 UNDERTAKER & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71231

CERTIFICATE OF DEATH.

D71231

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2005 Howard Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward S. Reinicker

(Residence in Baltimore: No. 2005 Howard

62 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M.	White	Married

6-DATE OF BIRTH, July (Month) 11 (Day), 1860 (Year)

7-AGE, 62 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work R. R.
(b) General nature of industry, business, or establishment in which employed (or employer) Retired

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Reinicker

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Imm

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Shuzuska

(Address) 2005 Howard

15-

Filed JAN 16 1923. 191.

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

Coroner Pettis 5-8 E Fayette

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 15, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, autopsy or inquiry.) and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) 2 yrs. mos. ds.

(Signed) J. H. Pettis M. D.
(Coroner.)

1-15 1923 (Address) 508 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill

DATE OF BURIAL, 1/17, 19

20-UNDERTAKER Wm Cook

ADDRESS 502 E Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71232
1-PLACE OF DEATH

90 D71232
REGISTERED NO.

CITY OF BALTIMORE: (No. Bessemer Ave. ST. Gracland Park WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia F. Pirie

(a) RESIDENCE. No Bessemer Ave. ST. Gracland Pk. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William M. Pirie

6 DATE OF BIRTH (month, day, and year) July 4. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) New York N.Y.

PARENTS

10 NAME OF FATHER Simon K. Burkholder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Stanton Va

12 MAIDEN NAME OF MOTHER Susan R. Christmen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown Va

14 Informant Edward F. Pirie
(Address) Bessemer Ave, Catonsville Md

15 Filed JAN 16 1923 ROBERT A. KRAUSE Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1923, to Jan 15, 1923, that I last saw h[illegible] alive on Jan 14, 1923, and that death occurred, on the date stated above, at 5-30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. W. Kries, M. D.

1/15 1923 (Address) Dundalk, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL Jan 17 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

Townsend ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71233

CERTIFICATE OF DEATH.

38 D71233

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME James E. Towsend

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) N H D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records. (Address)

15 JAN 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1919 to January 13, 1923.

that I last saw him alive on January 12, 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Abs Spastic paraplegia (Syphilitic)

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Wass. Elisa; C.S.F.

(Signed) Clyde McNeil, M. D.

1/16/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ridge Cem. Dalto Co

DATE OF BURIAL Jan. 17 1923

20 UNDERTAKER William Cook

ADDRESS 502 E. North

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71234

CERTIFICATE OF DEATH.

100-001 D71234

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No.) ST., 70 WARD)

2-FULL NAME Elizabeth Smith

(a) RESIDENCE NO. 650 N. Fulton Ave (Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

070

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant (Address) Bay View Hospital Balto, Md.

15 Filed JAN 16 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1923 to Jan. 15 1923

that I last saw h[illegible] alive on Jan. 15 1923

and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Brain Disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. Goldsmith, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill DATE OF BURIAL Jan 17 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E. North

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71235
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

47 D71235
REGISTERED NO. C

CITY OF BALTIMORE: (No. 518 S. 14th St. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Rosario

(Residence in Baltimore: No. 518 S. 14th St. St.; 40 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 6th, 1862
(Month) (Day) (Year)

7-AGE, 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... W. W.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 537

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Philip Vogelsang

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Philip Schuler

(Address) 516 S 14th W

15- Filed JAN 16 1923, 191..... ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 / 14 / 23, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/14/21 191..., to 1/14/23 191...,
that I saw ... alive on 1/14/23 191...,
and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Mediastinum

(Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma Breast

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Jan 18, 1923

20-UNDERTAKER John J. Cowan & Son ADDRESS 701 Hollins St

Spec.—1-10-21—M&T—1500 Bks.

D71236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71236

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Greenmount Ave WARD) 10

2-FULL NAME Philip M Keene

(a) RESIDENCE No. 1213 Greenmount Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 24-1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Automobile

(b) General nature of industry, business, or establishment in which employed (or employer) Mechanic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jas L. Keene

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Alma M Reardon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Alma M. Keene

(Address) 1213 Greenmount Ave

15 JAN 16 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1922, to Jan. 14, 1923, that I last saw him alive on Jan. 12, 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum test

(Signed) E. Blumtock M. D.

1923 (Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL Jan 17 1923

20 UNDERTAKER H C Wendelken

ADDRESS 914 Fremont Ave

Spec.—1-10-21—M&T—1500 Bks.

Lucia Zanti

D71237

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71237

CERTIFICATE OF DEATH.

4 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 673 W. Saratoga ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucia Zanti

(a) RESIDENCE NO. 673 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24/22

7 AGE Years Months Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Zanti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Sperduto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant

(Address)

15 Filed JAN 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1922, to Jan 16, 1923, that I last saw h[illegible] alive on Jan 15, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jack L. Valentine M. D.

16, 1923 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71238

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 730 W. Lexington ST.: 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Frank

(a) RESIDENCE. NO. 730 W Lexington ST., 4th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 21-1914

7 AGE — Years: 8 — Months: 9 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Sol Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sadie Blum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Sol Frank 730 W Lexington St

15 Filed JAN 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to Jan 15, 1923,

that I last saw her alive on Jan 15, 1923, 5 P m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Cardiac paralysis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Diphtheria

(duration) ... yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. L. Lichtenberg, M. D.

1/15, 1923 (Address) 2 W N Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — DATE OF BURIAL: Jan 16 1923

20 UNDERTAKER: J. Ahrens & Co — ADDRESS: 1611 Mad ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71239

CERTIFICATE OF DEATH.

118-002 D71239

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital) (WARD)

2-FULL NAME Mary L. Baker

(a) RESIDENCE NO. 823 N. Gilmore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laurence W Baker

6 DATE OF BIRTH (month, day, and year): Aug 20 1852

7 AGE — Years: 70 — Months: 4 — Days: 26 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

037

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: A. Schofield

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Elizabeth Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Hospital Records

15 JAN 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 15 19 23

17 I HEREBY CERTIFY, That I attended deceased from Jan. 12, 19 23, to Jan. 15, 19 23,

that I last saw her alive on Jan. 15 19 23

and that death occurred, on the date stated above, at 9:35 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction due to post operative adhesions (operation 4 yrs ago)

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) (Acute Hemorrhagic pancreatitis ?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of Jan. 13, 23

Was there an autopsy? yes

What test confirmed diagnosis? autopsy + operation

(Signed) G. C. Stalley, M. D.

1/, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Jan 17, 1923

20 UNDERTAKER: Wm J Pickerell — ADDRESS: Mt Royal

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71240

CERTIFICATE OF DEATH.

129 D71240

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 444 E. 28th St ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Joseph Hamilton

(a) RESIDENCE. No. 444 E-28th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Whit	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Hamilton

6 DATE OF BIRTH (month, day, and year) Dec 3-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Medical Doctor

(b) General nature of industry, business, or establishment in which employed (or employer) Practice Medicine

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Randboro P.Q. Canada

PARENTS

10 NAME OF FATHER John Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Martha Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Mrs. Sarah Hamilton (Wife)
(Address) 444 E. 28th St

15 Filed JAN 15 1923
ROBERT R. KRAETER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1922, to Jan 14, 1923, that I last saw h[illegible] alive on Jan 14th, 1923, and that death occurred, on the date stated above, at 7-10 P m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer.
Terminating in Hemorrhage,

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Pneumonia
Tuberculosis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J Bennett Large, M. D.

, 19 (Address) 746 Dolphin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Vault	Jan. 17 1923
20 UNDERTAKER Lilly & Zeile	ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71241

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71241

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 Somerset ST.: 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Hancock

(a) RESIDENCE. No. 818 Somerset ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carliss Hancock

6 DATE OF BIRTH (month, day, and year): Feb 28-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont know

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont know

11 Informant: Francis Hancock

(Address): 818 Somerset

15 JAN 16 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1 — 14 — 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Jan 14, 1923, that I last saw h[illegible] alive on Jan 14, 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pelvic carcinoma & cachexia

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. A. Hirschstein, M. D.

1/16, 1923 (Address) 733 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 1/17 1923

20 UNDERTAKER: William Cook

ADDRESS: Soulsville

Spec.—1-19-21—M&T—1500 Blks.

D71242

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71242

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 8 WARD)

2-FULL NAME Samuel D. Cunningham

(a) RESIDENCE No. 1319 N. Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah M. McWilliams ~~Unknown~~

6 DATE OF BIRTH (month, day, and year) July 12, 1842

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
80	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Sam.D. Dunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant (Address) Municipal Hospital Records.

15 JAN 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from January 13, 1923, to January 15, 1923, that I last saw him alive on January 15, 1923, and that death occurred, on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (with uremia)

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical etc

(Signed) Clyde M. Reed, M. D.

1/15/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bell Cemetery

DATE OF BURIAL 1/17 1923

20 UNDERTAKER E J Manning & Son

ADDRESS 1938 E Lafayette Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71243

D71243

CERTIFICATE OF DEATH.

10

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Normat

(a) RESIDENCE. No. 29 S. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 6. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Mike Normat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Alchimowicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Alechimowicz
(Address) 29 S Bond St

15 Filed JAN 16 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 1. 1923. to Jan 15. 1923.
that I last saw her alive on Jan 15. 1923.
and that death occurred, on the date stated above, at 330 p. m.
The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Tracheotomy 1/15/23 Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. Macgowan M. D.

1/16. 1923 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	1/16. 1923
20 UNDERTAKER	ADDRESS
Jacob Fialkow & Co	618 Easter

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71244

CERTIFICATE OF DEATH.

101-001

D71244

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) I529 E: North Ave. ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma G: Trauty.

(a) RESIDENCE NO. I529 E: North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Trauty

6 DATE OF BIRTH (month, day, and year) June 15th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Underwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Henry Trauty (Address) I529 E: North Ave

15 Filed Jan 16 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

N 16 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14th 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 7 , 1923 , to Jan 14 , 1923 , that I last saw her alive on Jan 14 , 1923 and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (right)

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY — (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis?

(Signed) John J. Krug M. D.

Jan 16 1923 (Address) 1425 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Jan 17 1923

20 UNDERTAKER John Zellerick

ADDRESS 208 Orleans

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71245

CERTIFICATE OF DEATH.

101-001 D71245

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 910 N. Ninth (St.) (Ward) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Stegenhardt

(a) RESIDENCE. No. 910 N Ninth St., Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of Sadie Stegenhardt

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Frederick Stegenhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Sadie Stegenhardt (Address) 910 N. Ninth St.

15 JAN 16 1923 Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1923, to Jan 15, 1923, that I last saw him alive on Jan 15, 1923, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo W Jennings M.D.

JAN 16 1923 (Address) 1104 Lexington Bld

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Baltimore — DATE OF BURIAL: JAN 18 1923

20 UNDERTAKER: Geo W Little — ADDRESS 2750 EDMONDSON AVE.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71246

CERTIFICATE OF DEATH.

101-001 D71246

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 2542 No. Henry ST., 70 WARD)

2-FULL NAME Annette Evans

(a) RESIDENCE NO. 2542 No. Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 11 1911

7 AGE: Years 11; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Joseph J. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Kenna

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Joseph J. Evans

(Address) 2542 No. Henry St

15 Robert F. Harrison, Registrar

JAN 16 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Jan 14, 1923,

that I last saw her alive on Jan 14, 1923,

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard A Jones M. D.

, 19 (Address) 1600 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL 19

20 UNDERTAKER: J. B. Heffernan

ADDRESS 2356 Eutaw Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71247

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71247

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Cayer

(a) RESIDENCE NO. 1300 Williams ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 33 yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Eva Cayer

6 DATE OF BIRTH (month, day, and year) Oct 18 - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Frank Cayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Eva Cayer

(Address) 1426 W. Franklin St

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

JAN 16 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14, 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1922 to Jan. 14, 1922, that I last saw him alive on Jan 14, 1922 and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) J. J. Kruger, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Holy Cross Cemetery

DATE OF BURIAL (now) 17, 1922

20 UNDERTAKER F. A. Krause & Son

ADDRESS 72 Hanover

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71248

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71248

CERTIFICATE OF DEATH.

40

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 17 WARD)

2-FULL NAME Mozie Smith

(a) RESIDENCE NO. 609 Orchard ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jesse Smith.

6 DATE OF BIRTH (month, day, and year): Nov. 27. 1894.

7 AGE — Years: 28. Months: 1 Days: 13. If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Peter Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Annie Johnson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant .....

(Address) .....

15 Filed ..... 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 10 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30. 1922, to Jan. 10. 1923, that I last saw h[illegible] alive on Jan. 10, 1923, and that death occurred, on the date stated above, at 2 40 P. m.

The CAUSE OF DEATH* was as follows: Bilateral Salpingitis

(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Bilateral Pneumonia

(duration) yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 1-6-23

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms & Operation

(Signed) ..... M. D.

..... 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

JAN 16 1923

MORGUE

WARNING—RESERVED FOR [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71249 D71249

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Archie Wooden

(a) RESIDENCE NO. 101 Winter St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Wooden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records.

(Address)

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 12 1923

17

I HEREBY CERTIFY, That I attended deceased from January 11, 1923, to January 12, 1923.

that I last saw him alive on January 12, 1923.

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Degenerative Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Daniels M. D.

1/13/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

per. Wm. E. Woodall

JAN 16 1923

Spec.—1-10-21—M&T—1500 Bks.

D71250

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71250

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis ST., 17 WARD)

2-FULL NAME Leroy Thomas

(a) RESIDENCE NO. 922 pennsylvania ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER ~~Rosa Ann Baltimore~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Caroline

14 Informant Hospital Records (Address) M.T.H.

15 Robert P. Harrison, ... 19 ..... Registrar

JAN 16 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1922, to Jan. 13, 1923,

that I last saw him alive on Jan. 13, 1923,

and that death occurred, on the date stated above, at 2.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 2 ? mos ds.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? T. B. in sputum, X-ra

(Signed) Duncan L. Graham M. D.

1-16-23, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

JAN 16 1923

WARNING—RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71251

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71251

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 N. Fremont Ave ST.: 17 WARD)

2-FULL NAME Billie Sayers

(a) RESIDENCE. No. 833 N. Fremont Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 12/1923

7 AGE — Years — Months — Days 1 — If LESS than 1 day, 3 hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Sayers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Parkersburg Va

12 MAIDEN NAME OF MOTHER Bettie Hoge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Laura Hoge

(Address) 833 Fremont ave

15 Filed ... 19... Registrar

16923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 19

17 I HEREBY CERTIFY, That I attended deceased from Jan. 12. 1923. to Jan. 14. 1923.

that I last saw her alive on Jan. 13. 1923.

and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Parkersburg

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Robert C. Blake M. D.

. 19 (Address) 1014 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A & Co

DATE OF BURIAL Jan 16 19

20 UNDERTAKER A. M. Walker

ADDRESS 723 W Lafayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71252

CERTIFICATE OF DEATH.

1429

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST.; WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Donaldson

(a) RESIDENCE. NO. 1430 Riverside Ave ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: W. F. Donaldson

6 DATE OF BIRTH (month, day, and year): ? 1873

7 AGE: Years 49; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work: Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Prince Geo Co Md

PARENTS

10 NAME OF FATHER: Wm Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country): Prince Geo Co Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Prince Geo Co Md

14 Informant (Address): W. F. Donaldson 1430 Riverside Ave

15 Robert P. Mattis, Registrar

Burial Permit Clerk.

JAN 16 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-14-23

17 I HEREBY CERTIFY, That I attended deceased from 3-1-22 19 . to 1-14-23 19 .

that I last saw her alive on 1-14-23 19 .

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uremia

Arterial Hypertension (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (doration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical findings

(Signed) Edward F. Morris M. D.

1-16-23 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 1/17 1923

20 UNDERTAKER: J. Kelly & Sons

ADDRESS: 318 Light St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 71253 HEALTH DEPARTMENT—CITY OF BALTIMORE D71253

CERTIFICATE OF DEATH.

Registered No. C. 199

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Justina Balaroni

(Residence in Baltimore: No. 2131 Stollmeyer St.; yrs. 6 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, ~~Widowed,~~ or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Sept. 28 (Month) (Day) 1887 (Year)

7-AGE. 33 yrs. 3 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). At Home

9-BIRTHPLACE. (State or Country). Balto Md

PARENTS:

10-NAME OF FATHER. John A. Boone

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Justina Gries

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarance A. Beamer

(Address) 2131 Stollmeyer St

15- Filed JAN 16 1923 192 Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. January 13 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Abortion cause unknown

(Duration) 5 yrs. mos. ds.

(Signed) J. C. A. Carter M. D. (Coroner.)

1-16 1923 (Address) 506 E. Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Western Cemetery DATE OF BURIAL. Jan. 16 1923

20-UNDERTAKER. George L. Schwab ADDRESS 2101 Eutaw Pl.

(Knowell)

Spec.—1-10-21—M&T—1500 Bks.

D71254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71254

86-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Knowell

(a) RESIDENCE NO. 943 S. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Knowell

6 DATE OF BIRTH (month, day, and year) Dec 31 - 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33.	1	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 0410

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Michael Knowell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Male Cola

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mary Knowell

(Address) 243 S. Eden St

15 Filed JAN 16 1923, 19 Robert P. Harris, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1922, to Jan. 15, 1923

that I last saw h[illegible] alive on Jan 15, 1923,

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic otitis media, right side

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lateral sinus thrombosis(?) Septicemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1-3-23 / 1-12-23

Was there an autopsy? no

What test confirmed diagnosis? Culpepper

(Signed) [illegible], M. D.

, 19 (Address) Mercy, Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem. DATE OF BURIAL Jan 17 1923

20 UNDERTAKER Wendel Dippel & Son ADDRESS 37 S Eutaw St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71255 HEALTH DEPARTMENT—CITY OF BALTIMORE D71255

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Julia Leti

(a) RESIDENCE NO. 336 S. Caroline St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Italian White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~: Philip Leti

6 DATE OF BIRTH (month, day, and year): Unknown 1882

7 AGE: Years 40; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Severio Lipo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: John Leti

(Address): 336 S. Caroline St

15 Filed . 19 . Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1923, to Jan. 15, 1923, that I last saw her alive on Jan. 15, 1923, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema beginning Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Cholecystitis.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 13, 23

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Wm. J. Fulton, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer. DATE OF BURIAL: Jan 17 1923

20 UNDERTAKER: Wendel Dippel & Son ADDRESS: 378 S. Conkling St

JAN 16 1923

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71256

CERTIFICATE OF DEATH.

113 D71256

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 703 S. Castan ST. 26 WARD)

2-FULL NAME Daniel W. Szymanski

(a) RESIDENCE NO. 703 S Ellwood Av ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? 3 yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1922-Oct 4

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Ignacy Szymanski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Cyneldia Gostomska

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Ignacy Szymanski (Address) 703 S. Castan

15 FILED JAN 17 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1923, to Jan 16, 1923, that I last saw him alive on Jan 15, 1923, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Leo. Heller M. D.

1/16, 1923 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Jan 17 1923
20 UNDERTAKER	ADDRESS
Stephen J Trakowski	1008 S. Kenwood Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71257

CERTIFICATE OF DEATH.

154 D71257

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 S. Bouldin ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Francis Prus

(a) RESIDENCE. No. 1008 S. Bouldin ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Jan 2 23

7 AGE — Years — Months — Days: 14 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED: none

(a) Trade, profession or particular kind of work: —

(b) General nature of Industry, business, or establishment in which employed (or employer): infant

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Prus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Rozionska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: John Prus
(Address): 1008 S. Bouldin

15 JAN 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Jan 16, 1923, that I last saw h.m. alive on Jan 15, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

abcesses - on head neck & torso - Probably from Pemphigus neonatorum

(duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (Secondary): Septicemia (Exhaustion)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

1/16, 1923 (Address) 1014 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem. — DATE OF BURIAL: Jan 17 1923

20 UNDERTAKER: Stephen J. Galkowski — ADDRESS: 1001 Hanover

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71258

CERTIFICATE OF DEATH.

90 D71258

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 206 N. Arlington Ave. ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Lee

(a) RESIDENCE NO. 206 N. Arlington Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Lee

6 DATE OF BIRTH (month, day, and year) May ? 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
74	8	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Took in washing

(c) Name of employer Herself.

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER George Strickland.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co.

14 Informant Geo. Lee (Grand Son)

(Address) 206 N. Arlington Ave.

15 JAN 17 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13, 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 10th. 1923, to Jan. 13th. 1923.

that I last saw h... alive on Jan. 13, 1923, 19,

and that death occurred, on the date stated above, at 12 P.M. m.

The CAUSE OF DEATH* was as follows:

Broken Compensation

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Mitral Ins.

(duration) 1. yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam c

(Signed) Walter S. Jackson M.D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Jan 17 19 23

20 UNDERTAKER James H Dennis

ADDRESS 1203 Pennsylvania

Spec.—6-9-19—H. P. Co.—1000 Blks.

D71259

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71259

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 N. Eden ST.; or WARD) 5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Hewlett (Hughlett)

(a) RESIDENCE. NO. 210 N. Eden ST., 5 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Spencer Hewlett

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment(in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER David Calburn

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca Hall

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant (Address) Spencer Hewlett 210 N. Eden St

15 Filed JAN 17 1923 . 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1922, to Jan 14, 1923, that I last saw h[illegible] alive on Jan 14, 1923, and that death occurred, on the date stated above, at 10.05 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam. of sputum

(Signed) Robt. J. Greene, M. D.

1-15-1923 (Address) 120 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Jan 17 1923
20 UNDERTAKER John W Henderson	ADDRESS 1502 Eastwood

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71260 — 90c — D71260

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No.) 2112 St Paul St. — WARD 12

2 FULL NAME James Scott

(Residence in Baltimore: No.) 2112 St Paul St (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(St.; yrs. 60 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX M. — 4 COLOR OR RACE W.

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word) Widower

6 DATE OF BIRTH Oct 1 (Month) (Day) 1835 (Year)

7 AGE. 87 yrs. 3 mos. 5 ds. If LESS than 1 day, hrs. or min.

8 OCCUPATION. (a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE. (State or Country) England

PARENTS.

10 NAME OF FATHER Chas Scott

11 BIRTHPLACE OF FATHER (State or Country) England

12 MAIDEN NAME OF MOTHER Mary Daniel

13 BIRTHPLACE OF MOTHER (State or Country) Wales

14 I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Scott

(Address) 2112 St Paul St

15

FILED JAN 17 1923. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 15 (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry) and that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Obstruction disease of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) John F. Monroe, M. D.

(Corner.) Jan 17, 1923 (Address) 1492 Poland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE. (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Woodlawn Cem. DATE OF BURIAL Jan 19, 1923

20 UNDERTAKER John Cottrell Jr. ADDRESS 1700 N. Fayette

CAUSE OF DEATH must be filled in plainly, so that every item may be important. See instructions on back of certificate.

D71261 HEALTH DEPARTMENT—CITY OF BALTIMORE D71261

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C 1674-00

City of BALTIMORE: (No. 606 N. Carrollton Ave, St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. A. Wilkins

(Residence in Baltimore: No. 606 N. Carrollton Ave, St.; 71 yrs., 1 mos. 28 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.): married

6-DATE OF BIRTH: Nov. 18, 1851 (Month) (Day) (Year)

7-AGE: 71 yrs. 1 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Saddlery Business

9-BIRTHPLACE, (State or Country): Balto Md.

PARENTS:

10-NAME OF FATHER: Barth's Wilkins

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Frances Grimes ~~W. C. Wilkins~~

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. C. Wilkins

(Address) 606 N. Carrollton Ave

15- FILED JAN 17 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 14, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) U.S. Lunacy

(Duration) 1 yrs. ...mos. ...ds.

(Signed) J. T. Henneson M. D. (Coroner.)

Jan. 16 1923 (Address) 2 E. Edmondson Ave,

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenmount Cem. DATE OF BURIAL: Jan 19 1923

20-UNDERTAKER: J. Bittinger & Son ADDRESS: Lafayette

D71262

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

CERTIFICATE OF DEATH.

D71262

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2668 Wilkens ave. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Sarah E Ehlers

(Residence in Baltimore: No. 2668 Wilkens ave St.; yrs. 57 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Sept. (Month) 6 (Day) 1864 (Year)

7-AGE. 58 yrs. 4 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of Industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE, (State or Country). Washington D C

PARENTS.

10-NAME OF FATHER. David McCain

11-BIRTHPLACE OF FATHER, (State or Country) Howard Co Md

12-MAIDEN NAME OF MOTHER. Mary E Dean

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Hoffmann

(Address) 7412 Barclay St

JAN 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan (Month) 15 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Oedema of lungs

(Duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) 1 yrs. mos. 15 ds.

(Signed) James M Kemler M. D. (Coroner.)

Jan 16 1923 (Address) 702 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cemetery	Jan. 18th 1923
20-UNDERTAKER.	ADDRESS
Wilson & Shriver	1018 Edmondson Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71263

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D71263

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Mc Donough ST., 7 WARD)

2-FULL NAME Catherine G Morphet

(a) RESIDENCE NO. 1009 Mc Donough ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 8th 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Edwin R Morphet

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ga

12 MAIDEN NAME OF MOTHER Jane Donovan

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Baltimore Md.

14 Informant Edwin R Morphet
(Address) 1009 Mc Donough St.

15 Filed JAN 17 1923 ROBERT R. KRAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1923, to Jan. 15, 1923,

that I last saw h alive on Jan. 15, 1923,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Marasmus (Gastric)

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Autopsy

(Signed) D. A. Wagness, M. D.

1, 15, 1923 (Address) 1002 Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Jan 17 1923

20 UNDERTAKER Robt F Turner Inc — ADDRESS 1412 E Broadway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71264

CERTIFICATE OF DEATH.

90 D71264

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 Aisquith St., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minachem Rubin

(a) RESIDENCE NO. 127 Aisquith St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1825

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	98	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work has never worked

(b) General nature of industry, business, or establishment in which employed (or employer) in the Last

(c) Name of employer 10 Years

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Charles Rubin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Linkan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Balto St

15 Filed JAN 17 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 16 23, 19 , to Jan 16 23, 19 , that I last saw h alive on Jan 16 23, 19 , and that death occurred, on the date stated above, at 12 05 m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D.

1/16, 19 (Address) 120 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL Jan 17 19 23

20 UNDERTAKER Jack Lewis 1439 E Balto — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71265

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D71265

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 512 S. 15th ST., (W) WARD)

2-FULL NAME George M. Baier

(a) RESIDENCE NO. 512 S. 15th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER George M. Baier

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Babara Sellman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant George M. Baier

(Address) 512 S. 15th St

15 Filed JAN 17 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 31st, 1922, to Jan 16, 1923, that I last saw him alive on Jan 15th, 1923, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

, 19 (Address) 4704 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Jan 19 1923

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Bridge

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71266

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D71266

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1165 Gorsuch av ST., 9 WARD)

2-FULL NAME Jacob Osol

(a) RESIDENCE NO. 1165 Gorsuch av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Osol

6 DATE OF BIRTH (month, day, and year) Dec 6 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saloonkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Latvia

PARENTS

10 NAME OF FATHER Jacob. Osol

11 BIRTHPLACE OF FATHER (city or town) (State or country) Latvia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Latvia

14 Informant Pauline Osol

(Address) 1165 Gorsuch ave

15 Filed JAN 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1922, to Jany 15, 1923, that I last saw h[illegible] alive on Jany 15, 1923, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. S. McKiethen, M. D.

Jany 16 23, 19 (Address) 232 N Mosh Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuel Cemetery	Jan 18 1923
20 UNDERTAKER	ADDRESS
Louis Heerman	325 E Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

Moffitt

D71267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71267

CERTIFICATE OF DEATH.

5 - 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Orleans ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Young Moffitt

(a) RESIDENCE. No. 1114 Orleans ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles M Moffitt

6 DATE OF BIRTH (month, day, and year): 10/77

7 AGE: Years 45 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home keeper

(b) General nature of industry, business, or establishment in which employed (or employer): Keeping house

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): South Carolina

PARENTS

10 NAME OF FATHER: Samuel Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. Carolina

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): South Carolina

14 Informant (Address): Jennie Hall 1114 Orleans St

15 Filed JAN 17 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1922, to Jan 14, 1923, that I last saw h alive on Jan 14, 1923, and that death occurred, on the date stated above, at 10:30P m.

The CAUSE OF DEATH was as follows:

Bright's Disease

(duration) Abt 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) R. Gaston Smith M. D.

Jan 17, 1923 (Address) 1304 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: Jan 17 1923

20 UNDERTAKER: R. C. Gross — ADDRESS: 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71268

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71268 + 73 D71268

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon Campbell White

(a) RESIDENCE NO. 1400 Fairmount ST., NW WARD Washington D.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Mrs Maud White.

6 DATE OF BIRTH (month, day, and year) Aug. 28 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Govt. Transportation

(c) Name of employer U.S. Govt

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Thomas White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Carolyn Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn.

14 Informant Johns Hopkins Hospital
(Address) Baltimore Md.

15 JAN 17 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1923

17

I HEREBY CERTIFY, That I attended deceased from June 12, 1922, to Jan 16, 1923,

that I last saw h[illegible] alive on Jan. 16, 1923,

and that death occurred, on the date stated above, at 2.50 A. m.

The CAUSE OF DEATH* was as follows:

Bulbo-bulbar palsy
associated with
hypertension.

(duration) 3 yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Washington D.C.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	May 17 1923
20 UNDERTAKER	ADDRESS
Robt. Turner	1127 U St.

D71269

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71269

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Mary to Mercy Hosp 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roger H. Ways (or Wayland)

(Residence in Baltimore: No. 1037 E. Monroe St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Sgle

6-DATE OF BIRTH, Oct. 7, 1900 (Month) (Day) (Year)

7-AGE, 12 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, W. A. ~~Highland~~ Wayland

11-BIRTHPLACE OF FATHER (State or Country), Balto " by land adopted by

12-MAIDEN NAME OF MOTHER Mary J. Hardy

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosamund Baur

(Address) 1035 Monroe

15- Filed JAN 17 1923 191... ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 13, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

Suicide (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D. (Coroner.)

Jan 15, 191 23 (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Jan 17, 1923

20-UNDERTAKER Harry H. Witzke

ADDRESS 1531 W. Lombard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Spec.—1-10-21—M&T—1500 Bks.

Phillips. 2300 Edmondson Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71270

CERTIFICATE OF DEATH.

D71270

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 W. Baltimore ST., 4 WARD)

2-FULL NAME Theadore R. West

(a) RESIDENCE NO. Bergie Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 4, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	17	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Christopher B West

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S.

12 MAIDEN NAME OF MOTHER Sallie Lamer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Mrs Ophie Lager

(Address) Bergie Md.

15 JAN 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1923 to Jan 18 1923.

that I last saw h alive on Jan 16 1923

and that death occurred, on the date stated above, at 1-30 a m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Nephritis, parenchymatous

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Swollen feet and face

(Signed) Thos. H Phillips, M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Jan 19 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E 25th St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook. Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

D71271

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D71271 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 519-N-Charles-St. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... John Morris Orem. 60-4-23

(Residence in Baltimore: No. 519-N-Charles-St. St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefuly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. August- (Month) 25 (Day) 1862 (Year)

7-AGE. 60 yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer) (self)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Wm. Morris Orem.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Helen Eliz. West,

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Edith A. Orem, (wife)

(Address) 519-N-Charles-St., City.

15 JAN 17 1923 Filed ..... 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 16 (Day) 23 (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) ..... M. D.
(Coroner.)

1-7-1923 (Address) 1423 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
GREEN MOUNT CEMETERY	Jan-19-23 19

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.—6-0-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71272
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

161-001 D71272
REGISTERED NO.

CITY OF BALTIMORE: (No. 839 Caledon Rd. St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Burns.

(a) RESIDENCE. No. 839 Caledon Rd. St., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.
(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16 1923

7 AGE Years Months Days If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS
10 NAME OF FATHER Harry Raymond Burns
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.
12 MAIDEN NAME OF MOTHER Rose Eliz Kelly
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Harry Raymond Burns 839 Caledon Rd.

15 JAN 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1923, to Jan 16, 1923
that I last saw h[illegible] alive on Jan 16, 1923
and that death occurred, on the date stated above, at 7.35 A m.
The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. 20 min ds.

CONTRIBUTORY (Secondary) Prematurity
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? None Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) [illegible] M. D.
Jan 16 1923 (Address) 2101 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL: Jan. 17 1923

20 UNDERTAKER: Margaret D. Flynn ADDRESS: 1422 Light St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71273

D71273

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Schlick

(a) RESIDENCE NO. 1033 McDonough St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1873 July 15

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
49	6	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Nicholas Schlick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dansville, N.Y.

12 MAIDEN NAME OF MOTHER Louise Scheulte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Municipal Hospital Records. (Address)

15 Dec. 1, 1923 Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15 1923

17

I HEREBY CERTIFY, That I attended deceased from January 15, 1923, to January 15, 1923, that I last saw him alive on January 15, 1923, and that death occurred, on the date stated above, at 9:35 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 24 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebro-spinal Syphilis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann 4/4 CSF +

(Signed) Clyde McNeil M. D.

1/16/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Jan 18 1923

20 UNDERTAKER Jenkler & Jenkler — ADDRESS 1739 Eager

B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT BEFORE BURIAL PERMIT IS ISSUED. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71274

CERTIFICATE OF DEATH.

124 D71274

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3114 Mc Elderry ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Benick

(a) RESIDENCE NO. 3114 Mc Elderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary

6 DATE OF BIRTH (month, day, and year): April 8th 1857

7 AGE: Years 71 Months 9 Days 9 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Vienna Austria

PARENTS

10 NAME OF FATHER: Leopold Benick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Wm L Benick

(Address) 3114 Mc Elderry St

15 Filed ... 19 ... Registrar

ROBERT A. BARRON

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 4 1923 to Jan 16 1923, that I last saw h[illegible] alive on Jan 16 1923, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Sclerotic Type

(duration) ... yrs. ? mos ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. J. Hoffmeister, M. D.

1/17, 1923 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakhill

DATE OF BURIAL: Jan 20 1923

20 UNDERTAKER: Zirkler & Zirkler

ADDRESS 1739 Eager

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 17 1923

Spec.—1-10-21—M&T—1500 Bks.

D71275

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71275

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2540 W. Henry ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis J. McGrath

(a) RESIDENCE NO. 2540 W. Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Lou J. McGrath

6 DATE OF BIRTH (month, day, and year) — — 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John J. Grasons

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Hall

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mrs. Louis McGrath
(Address) 2540 W. Henry St.

15 Filed Jan 17, 1923 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Jan 15, 1923.

That I last saw he alive on Jan 15, 1923

and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
(Tubercul)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tb

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C. Tuttle, M. D.

1/17, 1923 (Address) 215 Shallcross Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	1/18 1923
20 UNDERTAKER	ADDRESS
J. F. Tuhey & Sons	1316 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71276

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Craig

(a) RESIDENCE NO. 10 East St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2 1866

7 AGE Years 56 Months 3 Days 12

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land

PARENTS

10 NAME OF FATHER Samuel Craig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mary Land

12 MAIDEN NAME OF MOTHER Malieda?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mary Land

14 Informant Robert E. Harrison

(Address)

15 Filed Jan 17 1923 Robert E. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923 to Jan 12, 1923

that I last saw her alive on Jan 12, 1923,

and that death occurred, on the date stated above, at 3.40 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilitation

acute uremia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross & Microscopic

(Signed) D. J. Davis, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Hospital

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Stnc.—6-9-19—H. P. Co.—1000 Bks.

D71277

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71277

CERTIFICATE OF DEATH.

× 31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Freeman

(a) RESIDENCE. NO. ..... ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec-25-1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Springfield Ill.

PARENTS

10 NAME OF FATHER Jacob Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Charity Douglas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) P. J. Sweeney Woodlawn Md. Pen

15 JAN 17 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January-8 1923

17 I HEREBY CERTIFY, That I attended deceased from August-2-, 1922, to January-8, 1923, that I last saw him alive on January-7, 1923, and that death occurred, on the date stated above, at 4.50 a. m.

The CAUSE OF DEATH* was as follows:

Edema of Larynx and Exhaustion (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. 5 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of Sputum + Chest.

(Signed) William A. Schwartz, M. D.

Jan. 8, 1923 (Address) Maryland Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

JOHNS HOPKINS HOSPITAL — 19

20 UNDERTAKER — ADDRESS

Commissioner Health.

MORGUE

Per. Wm. A. Brosius

N.B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

(Stollenmaier)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71278 11-001 D71278

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Lemmon ST., 20 WARD)

2-FULL NAME Bernhard Stollenmaier

(a) RESIDENCE NO. 1907 Lemmon ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 31 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Stollenmaier

6 DATE OF BIRTH (month, day, and year) Oct. 16. 1856

7 AGE — Years 66 — Months 2 — Days 29 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. P. Stollenmaier Jr.
(Address) 3924 Hilkert Ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 10, 1923 to Jany 16, 1923 that I last saw h alive on Jany 16, 1923 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary) probably Grippe

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? x

(Signed) Gustav Dill, M. D.

Jany 17 1923 (Address) 1733 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Jan 19. 1923

20 UNDERTAKER C. W. Dill ADDRESS 3109 Fredk Ave

2. 171923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71279 D71279

CERTIFICATE OF DEATH.

161-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 N. Carrollton Ave. WARD) 7

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Tilley

(Residence in Baltimore: No. 1026 N. Carrollton Ave St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, Jan (Month) 15 (Day), 1923 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, 5 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Eugene Tilley

11-BIRTHPLACE OF FATHER (State or Country), U. S.

12-MAIDEN NAME OF MOTHER Marie Smith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marie Tilley

(Address) 1020 N. Carrollton Ave

15-

Filed ....Robert B.... Registrar.

1 7 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 15 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 15th 1923, to Jan 15th 1923, that I saw h[illegible] alive on Jan 15th 1923, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

1½ months Prematurity

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.

1-15-, 1923 (Address) 924 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Johns Hopkins Laboratory	....., 191...
20-UNDERTAKER	ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71280

CERTIFICATE OF DEATH.

129

D71280

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 510 S Spring ST., 3 WARD)

2-FULL NAME Robert J Thornton

(a) RESIDENCE NO. 510 S. Spring ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9/1/1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rev E E Johnson

(Address) 1426 Eastern Ave

15 Robert F. ... 19 ...

Registrar

JAN 17 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Jan 14, 1923, that I last saw him alive on Jan 14, 1923 and that death occurred, on the date stated above, at 7-30 p. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Bright's

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. E. Johnson, M. D.

, 19 (Address) 7 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	1/18/23

20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1135 Hanford Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71281

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71281

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 W. Fayette ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph W Stubbins Jr.

(a) RESIDENCE NO. 110 W. Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Sgl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-5-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph W Stubbins Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ethel Dahl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Joseph W. Stubbins
(Address) 110 W Fayette St

15 Robert P. Harrison, Registrar
Burial Permit Clerk.

JAN 17 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/15/23, 19

17 I HEREBY CERTIFY, That I attended deceased from
1/13/23, 19, to 1/15/23, 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at a. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Malnutrition & Enteritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms Attendant Circumstances

(Signed) [illegible], M. D.

1/17, 19 23 (Address) 110 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Jan 19 1923

20 UNDERTAKER John J. Fields

ADDRESS 1200 W. Fayette St

B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71282

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71282

CERTIFICATE OF DEATH.

9K

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeth Home 9 St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Marshal Barnes

(a) RESIDENCE. NO. St. Elizabeths Home Chestnut Hill Ave ST., WARD. Ellicott City Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	negro	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co.

PARENTS

10 NAME OF FATHER Marshal Barnes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co.

12 MAIDEN NAME OF MOTHER Elmira Barnes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co.

14 Informant St. Elizabeth Home (Address) Records

15 Filed . 19 Robert P. Burial Permit Clerk Registrar

N 171923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 17 1923

17 I HEREBY CERTIFY, That I attended deceased from December 20, 1922, to January 17, 1923, that I last saw him alive on January 16, 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Jan 17, 1923 (Address) 200 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

M. Felton Cem Jan 18 1923

20 UNDERTAKER — ADDRESS

Easton Sons Ellicott City

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71283 HEALTH DEPARTMENT—CITY OF BALTIMORE D71283

CERTIFICATE OF DEATH. 91-002

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2911 W Lanvale ST., 16 WARD)

2-FULL NAME Mary Redmond

(a) RESIDENCE NO. 2911 W Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Patrick Redmond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Emma Byrne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Mary Feller
(Address) 700 E Biddle St

15 Robert P. Harrison, .19.....
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 .1922. to January 16. 1923.
that I last saw her alive on January 15. 1923.
and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds. Unknown

18 Where was disease contracted if not at place of death? "

Did an operation precede death? " Date of "

Was there an autopsy? "

What test confirmed diagnosis? "

(Signed) M. A. O'Neill M. D.

1/17. 1923 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 1/18 1923

20 UNDERTAKER Martin Burkey Son — ADDRESS 1827 W North

N 17 1923

B.—WRITE PLAINLY, WITH UNFADING INK. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71284

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71284

CERTIFICATE OF DEATH.

188-003

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Fleet & Wolfe St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John Deepeaux

(Residence in Baltimore: No. 2012 Bank St St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. July (Month) unknown (Day) 1847 (Year)

7-AGE. 75 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). NO

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adam Deepeaux

(Address) 2012 Bank St.

15- JAN 18 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 15 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broken neck at once.

Struck by automobile driven and operated by Frank Rubanofski

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.

Jan 17 1923. (Coroner.) (Address) Curtis Bay

*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Balto Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	Jan 18 1923

20-UNDERTAKER. Peter Nicolaus ADDRESS 2060 Eastern

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Attending physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71285

CERTIFICATE OF DEATH.

74-002 D71285

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Rutland Ave ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalene Gleich

(a) RESIDENCE NO. 1615 Rutland Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Gleich

6 DATE OF BIRTH (month, day, and year): Dec 29 1864

7 AGE: Years 58 | Months | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: at home

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Michael Pfaff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dora Kuss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): John Gleich 1615 Rutland

15 Filed JAN 16 1923 ROBERT R. KRAUTER Deputy Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16 1923

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1923, to January 16, 1923, that I last saw her alive on January 15, 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) one hour

CONTRIBUTORY (Secondary) Thrombosis of veins of Leg

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Landrock, M. D.

Jan. 16 1923 (Address) 1242 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: Jan 19 1923

20 UNDERTAKER: John Zellrich — ADDRESS: 2[illegible] Eden

Spec. 6-9-19—H. P. Co. 1000 Bks.

(Stecker)

D71286 HEALTH DEPARTMENT—CITY OF BALTIMORE 23 D71286

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 N Haven ST. Stecker 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin J. Stecker

(a) RESIDENCE. No. 100 N Haven ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Dec 7 1922

7 AGE — Years: — Months: 3 Days: 7 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Gerald L. Stecker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Lucie E. Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Gerald L. Stecker
(Address): 122 N. Haven St

15 Filed . 19 JAN 18 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 13 1923, to Jan 16 1923, that I last saw h— alive on Jan 16 1923, and that death occurred, on the date stated above, at 1-30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

CONTRIBUTORY (Secondary) Convulsions (duration) yrs. mos. 4 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. R. Campbell M. D.

Jan 16. 1923 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenlawn

DATE OF BURIAL: Jan 18 1923

20 UNDERTAKER: E. Schumacher & Son

ADDRESS: Fremont

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dr Inglehart 1008 Cathedral

D71287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71287

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Oak Place & Charles St. Ave. WARD. 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie H. Dickey

(a) RESIDENCE. No. Oak Place & Chas St. Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William A.

6 DATE OF BIRTH (month, day, and year) 10/20/1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John J. Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary E. Hays

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant: Husband (Address) Wm A. Dickey Oak Pl. & Chas St Ave

15 Filed JAN 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-15 1923

17 I HEREBY CERTIFY, That I attended deceased from JAN. 11, 1923, to JAN. 15, 1923, that I last saw HER alive on JAN. 15, 1923, and that death occurred, on the date stated above, at 2.00 P m.

The CAUSE OF DEATH* was as follows:

CEREBRAL HEMORRHAGE
ARTERIOSCLEROSIS
HYPERTENSION

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John F. Dorsey M. D.

19 (Address) 1008 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park,	Jan. 18, 1923
20 UNDERTAKER	ADDRESS
Jno. O Mitchell	1201 W Fayette St.

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71288

CERTIFICATE OF DEATH.

38 D71288

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 N. Central ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred [redacted] Dennis

(Residence in Baltimore: No. 313 N. Central St.; ....yrs., ...mos. ....ds.)

N. B.—Every item of information should be carefully supplied. Age should be stated as definitely as possible. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widower

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1868. (Year)

7-AGE, 54 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Do

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, William Dennis

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Harriet Hurst

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Dunbar Foster

(Address) 313 N. Central Ave

15- JAN 18 1923 ROBERT R. KRAUTER.

Filed ....., 191.... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 16 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 1923, to Jan 16 1923, that I saw him alive on Jan 16 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Heart disease

or Chronic Endocarditis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Hypertension and Paralysis agitans

(Duration) ....yrs. ....mos. 6 ds.

(Signed) R. J. Young M. D.

1/18, 1923 (Address) 1472 Mount

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Jan 18, 1923

20-UNDERTAKER Wm. R. A. Elliott

ADDRESS 727 Eastern Ave.

Spec.—1-10-21—M&T—1500 Bks.

D71289 HEALTH DEPARTMENT—CITY OF BALTIMORE D71289

CERTIFICATE OF DEATH. X 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 Hillen ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruby McDuffie

(a) RESIDENCE NO. 1036 Hillen ST., WARD 2-6.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. 9 mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Chield

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Chield

6 DATE OF BIRTH (month, day, and year) Feb 8 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	11	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Non

(c) Name of employer Non

9 BIRTHPLACE (city or town) (State or country) D C

PARENTS

10 NAME OF FATHER Hillian H Mcduffie

11 BIRTHPLACE OF FATHER (city or town) (State or country) D C

12 MAIDEN NAME OF MOTHER Amy Reg Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D C

14 Informant Hillian H Mcduffie
(Address) 1036 Hillen St

15 Filed JAN 18 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 17 19 23

17 I HEREBY CERTIFY, That I attended deceased from January 15. 1923. to January 17. 1923. that I last saw her alive on January 16. 1923. and that death occurred, on the date stated above, at 4.15 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) Dr J W Kennard, M. D.

1-17 1923 (Address) 708 Cmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Jan 18 1923

20 UNDERTAKER Mrs Robert H Elliott — ADDRESS 1725 Ashland Av

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

160684 D71290 HEALTH DEPARTMENT—CITY OF BALTIMORE X 46 D71290

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL. ST. 3 WARD)

2-FULL NAME Lizzie Ringgold

(a) RESIDENCE NO. 313 S. Bethel St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 2 weeks yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50?	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent - Early

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown ?

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Friends

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 - 1923, to Jan 16 - 1923, that I last saw h[illegible] alive on Jan 16 - 1923, and that death occurred, on the date stated above, at 12.15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma ovary

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Jan. 16, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Howard R Bugg, M. D.

, 19 (Address) Johns Hopk. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL Jan 19 1923

20 UNDERTAKER Wm R A Elliott ADDRESS 1725 Ashland Av

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71291 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 D71291

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 S Chester ST., 1 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J Wilson

(a) RESIDENCE NO. 435 S Chester ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER William J wilson

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Margerett Osterlag

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant William J Wilson (Address) 435 S Chester St

15 Filed JAN 18 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17. 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 8, 1923, to Jany 17, 1923, that I last saw h— alive on Jan 17 1923 and that death occurred, on the date stated above, at 630 Am.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. F. Gollenberg, M. D.

Jan 17 1923 (Address) 1810 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel DATE OF BURIAL Jan 18 1923

20 UNDERTAKER John Maleber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state name should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71292

CERTIFICATE OF DEATH.

188-003 D71292

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 11 WARD) 1923

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Miller

(a) RESIDENCE NO. 939 Mason St. ST., WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jesse Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lucy Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Municipal Hospital Records.

(Address)

15 Filed JAN 18 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from January 8 1923 to January 15. 1923.

that I last saw h. alive on January 15 1923.

and that death occurred, on the date stated above, at 10:30 A.M.

THE CAUSE OF DEATH* was as follows:

Internal hemorrhage from traumatic (torn) aneurism of abdominal aorta struck by automobile several months ago. (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Automobile accident (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did operation precede death? Yes Date of Jan. 15, 1923.

Was there autopsy? Yes

What test confirmed diagnosis? Autopsy findings.

(Signed) [illegible] M. D.

1/16/1923 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 1/18/1923

20 UNDERTAKER Jane L. Kennedy

ADDRESS 578 N Bidd St

N. B.—WRITE PLAINLY. PHYSICIANS should state AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. mation is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-061 D71293

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1323 N. Stricker ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Banks

(a) RESIDENCE. No. 1323 N. Stricker ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate Banks

6 DATE OF BIRTH (month, day, and year): January 1850

7 AGE: Years 72 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cambridge Md

PARENTS

10 NAME OF FATHER: Wm. H. Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Kate Banks (Address) 1323 Stricker St

15 Filed ..... 19 ..... Registrar

1323 N. Stricker St

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923 to Jan 15, 1923 that I last saw h[illegible] alive on Jan 15, 1923 and that death occurred, on the date stated above, at 1.10 P.M.

The CAUSE OF DEATH was as follows: Paralysis Cerebral Hemorrhage

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Horsman M. D.

Jan 17 1923 (Address) 712 S Stricker St.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 1/18 1923

20 UNDERTAKER: Samuel Hemsley

ADDRESS 678 N Eden St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71294

CERTIFICATE OF DEATH.

1929 D71294

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 102 N. Monroe ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Whittle

(a) RESIDENCE. NO. 102 N. Monroe ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Margaret E. Whittle

6 DATE OF BIRTH (month, day, and year) Aug 30-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Whittle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Cynthia Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Margaret E. Whittle

(Address) 102 N. Monroe St.

15 JAN 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3 -, 1923, to Jan 16 -, 1923, that I last saw h[illegible] alive on Jan - 15 -, 1923, and that death occurred, on the date stated above, at 9:00 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) R. Heller Hemming, M. D.

1/17, 1923 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL / DATE OF BURIAL

London Park, Jan. 19 1923

20 UNDERTAKER ADDRESS

George L. Schwab 2101 Fulton Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D71295

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 N. Mound St ST., 19 WARD)

2-FULL NAME Audrey Beatrice Du Vall

(a) RESIDENCE NO. 11 N. Mound ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? (If non-resident give city or town and State) yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9. 1920

7 AGE — Years: 2 — Months: 4 — Days: 8 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto - Md

PARENTS

10 NAME OF FATHER George E. Du Vall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Joliet Ill

12 MAIDEN NAME OF MOTHER Blanche Overacker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Mr. George E. Du Vall
(Address) 11 N. Mound St

15 JAN 18 1923 ROBERT K. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1923

17 I HEREBY CERTIFY, That I attended deceased ~~from~~ 8 a m on 1-17 1923, to 12 Noon, 1923, that I last saw h~~i~~r alive on Jan 17, 1923 and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

— (duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ~~do~~

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Demonstration of organism

(Signed) R. D. Harman, M. D.

19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Jan. 18 1923

20 UNDERTAKER: Henry Hood Son — ADDRESS: 1301 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK. The information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71296

CERTIFICATE OF DEATH.

100-001 D71296

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Hanover ST. 23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cristofalo Russo

(a) RESIDENCE NO. 1017 Hanover ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 15 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE LEGIBLY. Use black ink. Fill in all blanks with information carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1-1-23

7 AGE — Years: — Months: — Days: 15 — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: son

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Cristofalo Russo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Josephine Tombarello

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Cristofalo Russo

(Address)

15 JAN 18 1923 HUBERT H. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-15 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-14- 1923 to 1-15 1923

that I last saw h[illegible] alive on 1-15 1923

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Diffuse Broncho Pneumonia.

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary): Broncho pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical.

(Signed) S. Adriance M. D.

1-16 1923 (Address) 100 Lincoln

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. A.C. — DATE OF BURIAL: 1/18/23

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Hanover

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71297

CERTIFICATE OF DEATH.

90 D71297

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1921 N. Saratoga ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Waldeck.

(a) RESIDENCE NO. 1921 N Saratoga ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Waldeck.

6 DATE OF BIRTH (month, day, and year) June 27 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Steinkamp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary E Marshain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. E Ferris

(Address) 1921 N Saratoga St

15 JAN 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 20 1921 to Jan 17 1923.

that I last saw h alive on Jan 14 1923

and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chron. Endocarditis

Arteriosclerosis Hypertension

(duration) 15 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Elmer B Freeman M. D.

, 19 (Address) 412 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Jan 20 1923

20 UNDERTAKER James Dignan & Son

ADDRESS 1000 S. Pace st

N. B. All items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D71298

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D71298

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 E. Lafayette ave St.; 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas E. Doyle

(Residence in Baltimore: No. 414 E. Lafayette ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the Word.)
Male	White	Single

6-DATE OF BIRTH. Aug. 26, 1920
(Month) (Day) (Year)

7-AGE. 2 yrs. 6 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER. Thomas Doyle

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Anna Madden

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Doyle

(Address) 414 E. Lafayette ave

15- JAN 18 1923 1923 B.O.C.H. E. KRAUSE
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. January 17, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 14 1923, to January 17 1923, that I saw h in alive on January 16 1923, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) W. D. Thomas M. D.

Jan. 18, 1923 (Address) 1228 W. Conolin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. New Cathedral cemetery

DATE OF BURIAL. Jan. 19, 1923

20-UNDERTAKER Richard H. Cooley

ADDRESS 438 E. Math ave

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D71299

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D71299

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ferguson Fowles

(a) RESIDENCE. No. Mt Hope Retreat ST.: 25th WARD. (Mississippi)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 0 ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr Fowles

6 DATE OF BIRTH (month, day, and year): about 1871

7 AGE — Years: 47 — Months: 0 — Days: 0 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Charleston S. C

PARENTS

10 NAME OF FATHER: Hugh Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country): (?) Ireland

12 MAIDEN NAME OF MOTHER: Sarah Jane Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charleston S.C.

14 Informant: Records of Mt Hope Remas

(Address): Mt Hope Md.

15 JAN 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 2nd, 1922, to June 15th, 1923, that I last saw her alive on June 15, 1923, and that death occurred, on the date stated above, at 2 P. M. m.

The CAUSE OF DEATH* was as follows:

Paralysis - R. Hemiplegia

Post Cerebral Hemorrhage - abt (duration) 0 yrs. 0 mos. 1/2 ds.

CONTRIBUTORY (Secondary) Anemia acute - abt (duration) 0 yrs. 10 mos. 0 ds.

18 Where was disease contracted if not at place of death? Mississippi

Did an operation precede death? No Date of

Was there an autopsy? No

What (es(confirmed dingnosis?)

(Signed) Frank J. Flannen, M. D.

Jan 19, 1923 (Address) M't Hope Remas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charleston S.C.

DATE OF BURIAL: Jan 18, 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71300 D71300 100-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5312 Winner Ave ST., 27 WARD)

2-FULL NAME Viola M. Killary

(a) RESIDENCE NO. 5312 Winner ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 20 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20/22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Geo. Killary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER Lillie Shrigg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mr Geo Killary

(Address) 5312 Winner Ave

15 Filed JAN 18 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 th 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Jan 17, 1923, that I last saw her alive on Jan 16, 1923 and that death occurred, on the date stated above, at 9.12 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. E. Krumbhaar, M. D.

1/17, 1923 (Address) 1602 N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Jan 19 1923

20 UNDERTAKER: Gorsuch Bayer & Lang

ADDRESS: 901 Hollins St

N. B.—WRITE PLAINLY with pen and ink. All questions must be answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

D71301 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71301

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., 24 Ward)

Registered No. C 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos J. Armiger

(Residence in Baltimore: No. 1229 Williams St' St.; 32 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Sept (Month) 15 (Day) 1886 (Year)

7-AGE. 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ford Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): Pullman Co

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Peter Armiger

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Rosa Lesner

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) May A. Armiger

(Address) 1229 Williams

15- Filed JAN 19 1923 ROBERT R. KRAUTER, Burial Permit Clerk (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 16 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, ~~autopsy or~~ Inquiry.) thereon and from the evidence obtained by said (Inquest, ~~autopsy or~~ Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) a few hours

CONTRIBUTORY (Secondary) Don't know

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. Coroner.

1-17 1923 (Address) 111 W Saratoga St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Cross Cem DATE OF BURIAL. 1-19 1923

20-UNDERTAKER. E. B. Hartle ADDRESS 115 E West St

N. B.—Every item of information should be carefully supplied. Note should be taken that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

160547 Med D71302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 49 D71302

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Fitzpatrick

(a) RESIDENCE NO. Richwood, Nicholas Co W. Va ST., WARD W. Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 weeks. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) April 27-1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER C. S. Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 FILED JAN 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17- 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 27-, 1922, to Jan 17-, 1923, that I last saw him alive on Jan 17-, 1923, and that death occurred, on the date stated above, at 5 45 a.m.

The CAUSE OF DEATH* was as follows:

Mediastinal Sarcoma

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R. Bagg M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richwood W. Va | DATE OF BURIAL Jan 18 1923

20 UNDERTAKER Joseph Abrams | ADDRESS 221 Bway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burns.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71303

D71303

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH St. Joseph Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... ST., 7 WARD)

2-FULL NAME Thomas W. Burns

(a) RESIDENCE NO. 961 N. Collington Ave ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Catherine Burns

6 DATE OF BIRTH (month, day, and year): Nov 13 1868

7 AGE: Years 54 Months 2 Days 3 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Motorman

(b) General nature of industry, business, or establishment in which employed (or employer): 678

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Benj. Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Rachel Crass

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Catherine Burns

(Address) 961 N. Collington Ave

JAN 18 1923 Filed ... 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16" 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1922, to Jan 16, 1923,

that I last saw h in alive on Jan. 16, 1923

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

CONTRIBUTORY (Secondary) Carcinoma stomach (duration) yrs. mos. ds.

(duration) since June 1922? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Dec. 14" 22.

Was there an autopsy? No.

What test confirmed diagnosis? U. S. S.

(Signed) Harold E. Pillsbury, M. D.

, 19 (Address) St Joseph Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: 1/19" 1923

20 UNDERTAKER: Chas. P. Evans & Son

ADDRESS: 1180 Mt Royal ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D71304

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3617 Fairview Ave ST. 15 WARD)

2-FULL NAME Charles A. Heller

(a) RESIDENCE NO. 3617 Fairview Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isabel Heller

6 DATE OF BIRTH (month, day, and year): Apr 20, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): General Merchant.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Petersburg, Va.

PARENTS

10 NAME OF FATHER: Jonas Heller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Pauline Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. David M. Ambach

(Address) 3617 Fairview Ave

15 Rec'd JAN 18 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/17/ 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 3, 1922, to Jan 17, 1923,

that I last saw him alive on Jan 17, 1923,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Diffuse Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter Talcott M. D.

1/17 1923 (Address) 2006 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem.

DATE OF BURIAL: 1/19/ 1923

20 UNDERTAKER: David Sondheim

ADDRESS: 118 W. Mt Royal Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71305

CERTIFICATE OF DEATH.

164 D71305

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1101 N. Broadway (WARD) 8

2-FULL NAME Rosabella Coleman

(a) RESIDENCE NO. 1101 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Joseph Coleman

6 DATE OF BIRTH (month, day, and year) Nov 8 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robert R. Cooper

11 BIRTHPLACE OF ~~FATHER~~ (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ruth McE Cleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Robert Coleman

(Address) 1101 N Broadway

15 Filed JAN 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 17. 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1923, to Jany 17, 1923,

that I last saw her alive on Jany 16, 1923

and that death occurred, on the date stated above, at 315 a m.

The CAUSE OF DEATH* was as follows:

Old age (General Debility)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fluneral Complications

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White Jr M. D.

1/17, 1923 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL Jan 19 1923

20 UNDERTAKER William Cook ADDRESS 502 E North

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71306 HEALTH DEPARTMENT—CITY OF BALTIMORE D71306

117

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarissa Hofstetter

(a) RESIDENCE NO. 840 Konig ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37.	7.	17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land

PARENTS

10 NAME OF FATHER Philip Hofstetter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Anna Dietsburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Philip Hofstetter

(Address) 840 Konig Street

15 Filed JAN 18 1923 Rudolph R. Krauter, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1923, to Jan. 17, 1923, that I last saw her alive on Jan 17, 1923, and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows: Broncho Pneumonia, Chronic Appendicitis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-12-23

Was there an autopsy?

What test confirmed diagnosis? Clin & Opes Signs

(Signed) J. H. Sandoe, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 1/20, 1923

20 UNDERTAKER Henry W. Mears & Son — ADDRESS 805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71307

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71307

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2414 Buchanan ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edecus J. Johnson

(a) RESIDENCE. No. 2414 Buchanan ST., 12 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 20 1892

7 AGE: Years 30 Months 2 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Rebecca C Fossett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Thomas H Johnson

(Address) 2414 Buchanan St

Filed JAN 18 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1922 to Jan 17, 1923

that I last saw h[illegible] alive on Jan 8, 1923

and that death occurred, on the date stated above, at 7.45 p.m.

The CAUSE OF DEATH* was as follows:

Vascular Heart Trouble

not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J Tompkins, M. D.

, 19 (Address) 414 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: Jan 19th 1923

20 UNDERTAKER: Emmert & Wright

ADDRESS: [illegible]

mation should be carefully supplied. AGE should be stated in YEARS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71308

CERTIFICATE OF DEATH.

57

D71308

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1924 W. Saratoga ST., 20 WARD)

2-FULL NAME Fredrick A Wayland

(a) RESIDENCE NO. 1924 W. Saratoga ST. 20 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write which word)
male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1st 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hanover (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Wayland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover Germany

12 MAIDEN NAME OF MOTHER Dortha Bunker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover Germany

14 Informant Clara E Wayland

(Address) 1924 W Saratoga St

Filed JAN 18 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10th, 1923, to Jan 17th, 1923, that I last saw him alive on Jan 17th, 1923, and that death occurred, on the date stated above, at 7 AM m.

The CAUSE OF DEATH* was as follows:

Diabetes Coma

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Urine Test & Symptoms

(Signed) John F Marlow, M. D.

19 (Address) 535 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL 1/19 1923

20 UNDERTAKER Robert Brotherton

ADDRESS Calhoun Hollins

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mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71309

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

4 100-001

Registered No. D71809

City of BALTIMORE: (No. 520 N Saratoga St. St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Le Roy Gough

(Residence in Baltimore: No. 520 N. Saratoga St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Don't Know (Month) (Day) (Year)

7-AGE: 2 yrs. 8 mos. 14 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto City

PARENTS:

10-NAME OF FATHER: Jacob Gough

11-BIRTHPLACE OF FATHER, (State or Country): B City

12-MAIDEN NAME OF MOTHER: Lida Gibson

13-BIRTHPLACE OF MOTHER, (State or Country): Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Gibson

(Address) 520 N Saratoga St

15-Filed JAN 18 1923 192

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jan (Month) 16 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) W K Jamison M. D. (Coroner)

1-18 1923 (Address) 1107 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Ind Cemetery — DATE OF BURIAL: 1-18 1923

20-UNDERTAKER: George H. Holland — ADDRESS: 1631 Linwood Ave Baltimore

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D71310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71310

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Langley

(a) RESIDENCE NO. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jack Langley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Delia Holmes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Hospital Records
(Address) M.T.H.

15 Filed JAN 18 1923 ROBERT R. KRAUTER, Registrar,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1923, to Jan. 15, 1923,

that I last saw him alive on Jan. 15, 1923,

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis L. Palaglucca M. D.

1-15-23, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner of Health.
JAN 18 1923

mation should be carefully supplied. AGE should be stated EXACTLY. INSTRUCTIONS for filling out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71311 ✓ 31 D71311

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Arlington Ave ST., 7th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie A Horton

(a) RESIDENCE NO. 706 Arlington Ave ST., Grand WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 12 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 22 - 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John W Horton

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary M Ellinghauser

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant John W Horton (Address) 706 Arlington Ave

15 Filed JAN 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1922, to Jan 15th, 1923, that I last saw h alive on Dec 6th, 1922, and that death occurred, on the date stated above, at 11, P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Anaemia (duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Physical Evidence

(Signed) Charles B. Hill, M. D.

19 (Address) Wyline Av. Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Jan 19 1923

20 UNDERTAKER Chas J Turner Sec — ADDRESS W. Balto

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71312

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-0 D71312

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Bells Gen Hosp ST., 4 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dulaney

(a) RESIDENCE No. 226 W. Fayette St ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 40 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced. (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 60 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseman Bowie Race Track

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER ? ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? ?

12 MAIDEN NAME OF MOTHER ? ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ?

14 Informant Lansing Dulaney

(Address) 4710 Park Heights Ave

15 JAN 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1923

17 I HEREBY CERTIFY, That I attended deceased from December 6, 1922 to January 17, 1923.

that I last saw him alive on January 30, 1923,

and that death occurred, on the date stated above, at 2 30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Primary anemia

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Hammon, M. D.

, 19 (Address) South Bells Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Cemetery

DATE OF BURIAL Jan 19 1923

20 UNDERTAKER Robt J Runs Inc

ADDRESS 1422 N Avenue

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malignant - origin of
which is unknown

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71313

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 S. Bouldin ST., 16 WARD)

2-FULL NAME Mary Anna Schroll.

(a) RESIDENCE No. 508 S. Bouldin ST., 16 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

29 D71313

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Schroll.

6 DATE OF BIRTH (month, day, and year) 1834.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Kripp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Anna Schroch (Daughter)

(Address) 508 S. Bouldin St

15 Filed JAN 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1923, to Jan. 16 1923, that I last saw h[illegible] alive on Jan 16 1923, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis Mitral Insufficiency,

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senility - Infirmities

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Jan. 19 23 (Address) 508 S. Bouldin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Jan. 19 1923

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71314

CERTIFICATE OF DEATH.

113 D71314

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 S Chapel St ST., 7 WARD)

2-FULL NAME Melvin C. Jenkins

(a) RESIDENCE NO. 305 S Chapel St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant.

6 DATE OF BIRTH (month, day, and year): December 14 1922.

7 AGE — Years: — Months: 2. Days: 7. If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John W Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Louisa Crouch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: John W. Jenkins (Address) 305 S Chapel St

15 Filed JAN 18 1923 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16 19 23

17 I HEREBY CERTIFY, That I attended deceased from Jan 14 19 23 to Jan 16 19 23

that I last saw h[illegible] alive on Jan 16 19 23

and that death occurred, on the date stated above, at 7 h m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Typical Cx

(Signed) Geo Claiborne Blades, M. D.

(Address) Jan 17 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel — DATE OF BURIAL: Jan 17 19 23

20 UNDERTAKER: Kendall J Hopps — ADDRESS: 1101 Hack.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71315

HEALTH DEPARTMENT--CITY OF BALTIMORE

D71315

CERTIFICATE OF DEATH

1 3

REGISTERED NO. C .....

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 228 West Hamburg St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Edward Brown

(Residence in Baltimore: No. 16 W Church St St.: 1 yrs. 1 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: colrd

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Nov (Month) 11 (Day), 1921 (Year)

7. AGE: 1 yrs. 1 mos. 27 ds. If LESS than 1 day, ... hrs. or — min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: not any
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or country): Balt Md

PARENTS

10. NAME OF FATHER: Edward Brown

11. BIRTHPLACE OF FATHER (State or country): Balt Md

12. MAIDEN NAME OF MOTHER: Myrtle Bordley

13. BIRTHPLACE OF MOTHER (State or country): Balt Md

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Myrtle Brown

(Address) 16 W Church St

15.

Filed JAN 18 1923 ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 191.., to Jan 16 1923.

that I saw h.. alive on Jan 16, 1923.

and that death occurred, on the date stated above, at 12: m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY) Toxemia

(Duration) yrs. mos. 3 ds.

(Signed) G E Burton M. D.

1/18/23, 191.. (Address) 301 E Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Auburn

DATE OF BURIAL: Jan 19 1923

20. UNDERTAKER: J. H. Brown & Son

ADDRESS: 1080 Montgomery St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71316

D71316

199

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Homewood Hospital

CITY OF BALTIMORE: (No. 2724 N. Charles ST., 27 WARD)

2-FULL NAME Mrs. Mabel Knopp

(a) RESIDENCE No. Raspburg, Md. ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mr. Harry C. Knopp

6 DATE OF BIRTH (month, day, and year) Apr 1, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28 yrs	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) ..... Anne Arundel Co
(State or country)

PARENTS

10 NAME OF FATHER A. B. Carey

11 BIRTHPLACE OF FATHER (city or town) Dec.
(State or country)

12 MAIDEN NAME OF MOTHER Clara Tracy

13 BIRTHPLACE OF MOTHER (city or town) Howard Co
(State or country)

14 Informant Husband Mr. Harry Knopp
(Address) Raspburg Md.

15 JAN 18 1923 Filed, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany. 14, 1923, to Jany. 16, 1923, that I last saw her alive on Jany. 15, 1923, and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Septic Abortion.
(See inquest)
O.K. Corner Romaine

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Abortion induced about
(duration) Jany 1, 1923 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Jany. 15, 1923

Was there an autopsy? no

What test confirmed diagnosis? Necrotic fragments found in uterus at operation.

(Signed) M. P. Shannon, M. D.

1/16, 1923 (Address) 3300 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Jan 18 23

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71317 ✓ 179 D71317

CERTIFICATE OF DEATH.

D71317

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 S. 15th St. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie C. Cartside

(a) RESIDENCE NO. 600 S. 15th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Cartside

6 DATE OF BIRTH (month, day, and year) Aug. 2nd 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	54	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew J. Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia A. Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant George A. Cartside (Address) 600 S. 15th St.

15 Filed JAN 18 1923 ROBERT H. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17th 19 23

17

I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1922, to Jan. 16, 1923, that I last saw h.e alive on Jan. 16, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 15-20 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) 1 yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hospital Exam.

(Signed) Henry B. Kelly M. D.

1/17, 19 23 (Address) 2504 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 19 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71318

CERTIFICATE OF DEATH.

111-D71318

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3501 (St.) Ash St (Ward) 12

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert E Shipley

(a) RESIDENCE. No. 3501 Ash St St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug 14 1909

7 AGE — Years: 13 — Months: 5 — Days: 3 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Scholar

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: George H. Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co Md

12 MAIDEN NAME OF MOTHER: Jane A Albin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant (Address): Mr. Geo. H. Shipley 3501 Ash St

15 Filed 1923 Robert P. Harrison, Registrar Burial Permit Clerk

N 1 6 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17th. 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 14th, 1923, to Jan 17th, 1923, that I last saw him alive on Jan 17th, 1923, and that death occurred, on the date stated above, at 3 45 P. m.

The CAUSE OF DEATH* was as follows:

Spinal Meningitis Tuberculous

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms.

(Signed) H. G. Leech, M. D.

Jan. 19 1923 Address) 1127 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's N. DATE OF BURIAL: Jan 19/23 19

20 UNDERTAKER: A. L. Marshall ADDRESS: 3539 Falls Rd

Every ... of in or-
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71319

CERTIFICATE OF DEATH.

31

D71319

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 Winchester ST.: 16 WARD)

2-FULL NAME John Hill

(a) RESIDENCE. No. 1523 Winchester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth T. Hill

6 DATE OF BIRTH (month, day, and year) Dec 24th 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	0	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carter Laborer 044
(b) General nature of industry, business, or establishment in which employed (or employer) Fish Establishment
(c) Name of employer Lamborn & Co

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md

PARENTS

10 NAME OF FATHER John B. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Fannie Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. Lottie Thomas
(Address) 1523 Winchester St

15 Filed 1 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 26th 1922, to Jan. 16th 1923, that I last saw h[illegible] alive on Jan 15th 1923, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma -

(duration) yrs. 0 mos. 28 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & examination

(Signed) Edw. Dill M. D.

, 19 (Address) 1204 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Jan 19 1923

20 UNDERTAKER Edward Ruggold — ADDRESS 1463 W. Fay St.

181923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

(Dodd)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71320 10 D71320

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST.) 14 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Dodd

(a) RESIDENCE. No. St. Vincent's asylum ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	1	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) not known

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) St. was foundling.

15 Filed 1 8 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1922, to Jan 17, 1923, that I last saw him alive on Jan 17, 1923, and that death occurred, on the date stated above, at 10:00 P m.

The CAUSE OF DEATH* was as follows:

Marasmus.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Diphtheria, nasal

(duration) 0 yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) [illegible], M. D.

1/18/23 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	1/18 1923
20 UNDERTAKER	ADDRESS
Martin Burkert	1521 W North Ave

NOTICE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71321

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71321

CERTIFICATE OF DEATH.

15 100-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1350 Woodyear Ln St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Colet Woods

(Residence in Baltimore: No. 1350 Woodyear Ln St.; yrs. 5 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	Sing

6-DATE OF BIRTH. Aug. 7, 1921
(Month) (Day) (Year)

7-AGE. 1 yrs. 5 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Infant

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Leon Spann

11-BIRTHPLACE OF FATHER, (State or Country) S. Carolina

12-MAIDEN NAME OF MOTHER. Alena Woods

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alena Woods

(Address) 1350 Woodyear St

15-

Jan 17 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) 1 yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

Jan. 17, 1923 (Address) 250 Edmonson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Cathedral DATE OF BURIAL. Jan 19, 1923

20-UNDERTAKER. Patrick A Dunn ADDRESS 131 3 Eastern

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

M 1 81923

D71322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71322

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 646 Raborg st. St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia L. Wright.

(Residence in Baltimore: No. 646 Raborg st. St.; yrs., 6) mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Female	Col.	Married

6-DATE OF BIRTH. Dont Know ..... 1..... (Month) (Day) (Year)

7-AGE. 26 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). 0 70

9-BIRTHPLACE, (State or Country). N. York.

PARENTS.

10-NAME OF FATHER. Dont Know

11-BIRTHPLACE OF FATHER, (State or Country) Dont know.

12-MAIDEN NAME OF MOTHER. Dont Known

13-BIRTHPLACE OF MOTHER, (State or Country) Dont known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Wright

(Address) 646 Raborg St

15-

Filed Robert F. Harrison, Registrar.

Burial Permit Clerk.

81923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 17 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy, or~~ Inquiry.) thereon and from the evidence obtained by said ..... (~~Inquest, autopsy or~~ Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) ..... yrs. Dont Know mos. ..... ds.

(Signed) H K Jenkins M. D.
(Coroner.)

1-18 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Pine Grove DATE OF BURIAL. Jan 19, 1923

20-UNDERTAKER. Howard A Lewis ADDRESS 312 Lanvale

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

4spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71323 — 118-00 — D71323

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hosp. (St.) 11 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Potthast

(a) RESIDENCE NO. 1174 W. Lanvale ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 50 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Potthast

6 DATE OF BIRTH (month, day, and year): Aug 11 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Fr. Lobb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Wm Potthast 1174 W Lanvale

15 Robert P. Harrison, Registrar

Burial Permit Clerk

JAN 18 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1923. to Jan 16, 1923.

that I last saw her alive on Jan 16, 1923.

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Strangulated Ventral hernia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of Dec. 23 1922

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) J. J. Rogers, M. D.

, 19 (Address) St Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: 1/19/23

20 UNDERTAKER: Edgar C. Tidy — ADDRESS: Fulton & Fayette

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71324 | 161-601 | D71324

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1225 Patapsco ST.; 23 WARD)

2-FULL NAME Baby Reynolds

(a) RESIDENCE. No. 1225 Patapsco ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-18-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER James W. Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lessie Rainier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James Reynolds
(Address) 1225 Patapsco St

15 Filed 1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-18, 1923, to 1-18, 1923, that I last saw h[illegible] alive on 1-18, 1923, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(5½ months gestation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Brown, M. D.

. 19 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross [illegible]	Jan. 19 1923
20 UNDERTAKER Margaret E. Egan	ADDRESS [illegible] St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 18 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71325

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71325

CERTIFICATE OF DEATH.

11-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 Byrd St.: 24 WARD)

2-FULL NAME James J. Fackley

(a) RESIDENCE NO. 1824 Byrd ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 14 22

7 AGE — Years: / Months: — Days: 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Michael Fackley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Cristina Feland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): Michael Fackley 1824 Byrd St.

15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/17 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/15/23, 19..., to 1/17, 1923, that I last saw h[illegible] alive on 1/17, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) P. J. Mull, M. D.

1923 (Address) 1211 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross R. C. Co

DATE OF BURIAL: 1/19 1923

20 UNDERTAKER: Maynard L. Flynn

ADDRESS: 1711 Mt. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71326 90 D71326

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 E. Thirteenth ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Helden Jr.

(a) RESIDENCE NO. 505-E. Thirteenth ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? ' yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M Helden.

6 DATE OF BIRTH (month, day, and year) Apr 18 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	61	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Peter Helden Sr

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs. P. Helden (Address) 505 E Thirteenth st

15 Filed JAN 18 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-16 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1923, to Jan 16, 1923.

that I last saw him alive on Jan 16, 1923.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Oedema of Lungs.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. 2½ mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. A. Leifschneider, M. D.

1/17, 1923 (Address) 293 9 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	1/19 1923
20 UNDERTAKER	ADDRESS
J. Fen McCully	130 E. Fort

INFORMATION SHOULD be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71327

60 - 001 D71327

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 Cloverdale Rd ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Beatrice Wilhide

(a) RESIDENCE No. 1225 Cloverdale Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr 20-1899

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
23	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John L. B. Wilhide

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Lehnert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John L. B. Wilhide (Address) 1225 Cloverdale Road

15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 1923 to Jan 17 1923

that I last saw her alive on Jan 17 1923

and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Coma — Graves Disease (now)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unable to give duration

Operation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Nov

Did an operation precede death? Yes Date of Dec 28-1922

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry C. Alger M. D.

1923 (Address) 3644 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: Jan 20 1923

20 UNDERTAKER: Wm J Pickerson Sons — ADDRESS: N Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71328

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71328

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 25 WARD) 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Kutz

(a) RESIDENCE NO. 36 Hazel st., Curtis Bay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kutz

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Ignatius Kutz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Dora Nowkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records

(Address) M.T.H.

15 JAN 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1922, to Jan. 18, 1923, that I last saw him alive on Jan. 18, 1923, and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum.

(Signed) Stanislaw L. Padaglinacs M. D.

1-18-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL 1/22 1923

20 UNDERTAKER William Fiaskowski — ADDRESS 168 Eastern Ave.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71329

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71329

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 142 Collins ave St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie E. Rippman

(Residence in Baltimore: No. 142 Collins ave St.; yrs. 49 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Aug (Month) 26 (Day) 1873 (Year)

7-AGE: 49 yrs. 4 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: Christ Hueb

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Mary Bleiring

13-BIRTHPLACE OF MOTHER, (State or Country): Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Rippman

(Address) 142 Collins ave

15-FILED JAN 19 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 16 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Degenerans

(Duration) 12 yrs. mos. ds.

CONTRIBUTORY ~~Ends~~ (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Fenton M. D. (Coroner.)

Jan 19 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: London Park Cemetery DATE OF BURIAL: Jan 19 1923

20-UNDERTAKER: Harry H. Witzke ADDRESS 1531 W Lombard

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71330 111-002 D71330

CERTIFICATE OF DEATH.

REGISTERED NO. 15

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

2-FULL NAME Harry Abramson

(a) RESIDENCE NO. 1746 Moreland Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: ~~Colored~~ White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 25, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Sam Goldman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Impenn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Leuss

(Address) 1439 E. Baltimore

15 Filed JAN 19 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 16, 1923, to Jan 18, 1923,

that I last saw him alive on Jan 18, 1923,

and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Perforated duodenal ulcer

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) General peritonitis

Toxemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan 15, 23

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) Daniel J Pessagno, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 1/19 1923

20 UNDERTAKER: Jack Leuss

ADDRESS: 1439 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71331

CERTIFICATE OF DEATH.

89 D71331

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 Granby Street ST., 3 WARD)

2-FULL NAME Solomon Glieckman

(a) RESIDENCE NO. 1006 Granby Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Glieckman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jock Lewis 1439 E. Baltimore St

15 Filed JAN 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18th 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 18th, 1923, to Jan. 18th, 1923, that I last saw him alive on Jan. 18th, 1923, and that death occurred, on the date stated above, at 11-10 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Snyder, M. D.

, 19 (Address) 38 So. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL Jan 19 1923

20 UNDERTAKER Jock Lewis

ADDRESS 1439 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71332 129 D71332

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 Cumberland St., ST., 14 WARD)

2-FULL NAME Morris Herling

(a) RESIDENCE NO. 529 Cumberland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Mollie

6 DATE OF BIRTH (month, day, and year) ——— 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Colthimg 68

(c) Name of employer

9 BIRTHPLACE (city or town) Riga
(State or country) Russia

PARENTS

10 NAME OF FATHER Max Herling

11 BIRTHPLACE OF FATHER (city or town) Riga
(State or country) Russia

12 MAIDEN NAME OF MOTHER Esther

13 BIRTHPLACE OF MOTHER (city or town) Riga
(State or country) Russia

14 Informant Mrs Mollie Herling
(Address) 529 Cumberland St

15 Filed JAN 19 1923 ISAAC R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH 1

16 DATE OF DEATH (month, day, and year) 1 -17- 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 14th, 1923, to Jan 17th, 1923, that I last saw him alive on Jan 17th, 1923, and that death occurred, on the date stated above, at 9.32 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

General Anasarca

Chronic myocarditis

(duration) yrs. 15 mos ds.

CONTRIBUTORY (Secondary) ascitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Path.

(Signed) N. A. Michelson, M. D.

, 19 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehrem Rosedale — DATE OF BURIAL Jan 19 1923

20 UNDERTAKER Jack Levin — ADDRESS 1437 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

D71333

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71333

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 105 N. Carollton ave ST., 6 WARD)

2-FULL NAME Katie Suskin

(a) RESIDENCE NO. 105 N Carollton ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 32 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 56 | Months — | Days — | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): I. Suskin 105 N. Carollton ave

15 JAN 19 1923 E26161 NVI

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/17. 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 16th, 1923, to Jan. 17th, 1923,

that I last saw her alive on Jan 16th, 1923,

and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
Chronic parenchymatous nephritis

(duration) 6 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): acute cardiac Dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) D.A. Mcculloch M. D.

1/19 23 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 1/18. 1923

20 UNDERTAKER: A. Lennon & Bro — ADDRESS 1127 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Bergeron)

D71334 HEALTH DEPARTMENT—CITY OF BALTIMORE D71334

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No. C 19 89

City of BALTIMORE: (No. 324 N Cary St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Bergeron

(Residence in Baltimore: No. 324 N Cary St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Unknown (Month) (Day) (Year)

7-AGE. 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work School Teacher (b) General nature of industry, business, or establishment in which employed (or employer) 068

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER. James Boyle

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Susan Hoffman

(Address) 2137 Penna Ave

15-

FILED JAN 19 1923 ROBERT R. KRAUSER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 18 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to h.s.g death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. Indefinite ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Hepburn M. D. (Coroner)

Jan 19 1923 (Address) 1006 Cherry

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral DATE OF BURIAL. 1-20- 1923

20-UNDERTAKER. H. C Brannigan Son ADDRESS 517 N Schroeder St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.--1-10-21--M&T--1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71335

CERTIFICATE OF DEATH.

31 D71335

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Kaiser

(a) RESIDENCE NO. 805 S. Rose st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Kaiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Bentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address) M. T. H.

15 Date JAN 19 1923 Joseph H. KRAUTH Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1921, to Jan. 18, 1923, that I last saw him alive on Jan. 18, 1923, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) Francis L. Delafield M. D.

1-18-23 (Address) Municipal Tuberculosis Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL 1/20 1923

20 UNDERTAKER Philip Henry

ADDRESS 2016 Orleans

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71336

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71336

CERTIFICATE OF DEATH.

101-001

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2495 Druid Hill Ave St. 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Laura E. Brewer

(Residence in Baltimore: No. 2495 Druid Hill ave St. 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX Fm.

4 COLOR OR RACE W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6 DATE OF BIRTH Unknown (Month) (Day) (Year)

7 AGE 75 Yrs. mos. ds.

If LESS than 1 day, hrs. or mln.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. Home
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9 BIRTHPLACE (State or Country) Balto Co. Md

PARENTS

10 NAME OF FATHER Robert Chenoweth

11 BIRTHPLACE OF FATHER (State or Country) Balto Co Md

12 MAIDEN NAME OF MOTHER Dorsey

13 BIRTHPLACE OF MOTHER (State or Country) Balto Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida M. Rouse

(Address) 3529 Rutland st

15 DATE JAN 19 1923 191

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH Jan (Month) 18 (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest, (Autopsy or Inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) S. M. Hourigan M. D.

Jan 19 1923 (Address) 3622 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Mt Olivet Cem DATE OF BURIAL Jan 20 1923

20 UNDERTAKER R J Dickman & Son ADDRESS 1 & 3 Mills Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2495 Druid Hill St., (Ward)

2-FULL NAME Laura Elizabeth Brewer

(a) RESIDENCE NO. 2495 Druid Hill Ave St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elias Brewer

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 70 years; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer ...

PARENTS

9 BIRTHPLACE (city or town) (State or country): Baltimore County Md

10 NAME OF FATHER: Robert Chenowith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore County

12 MAIDEN NAME OF MOTHER: Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore County Md

14 Informant: Ida Mathews Davis
(Address) 3529 Newland St Govans.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1923, to Jan 18, 1923, that I last saw h[er] alive on Jan 18, 1923, and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:
Coronary Thrombosis

(duration) ... yrs. ... mos 5 ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...
Did an operation precede death? No Date of ...
Was there an autopsy? No
What test confirmed diagnosis? ...

(Signed) Fred C Jewett, M. D.
Jan 18, 1923 (Address) 2576 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet — DATE OF BURIAL: Jan 20 1923

20 UNDERTAKER: Wm J Hickmerson — ADDRESS North Ave

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

Cynthia Hope

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71337

CERTIFICATE OF DEATH.

31 D71337

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 Morris ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cynthia Hope

(Residence in Baltimore: No. 1117 Morris St.; 5 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... 1881 ....., 1 .....
(Month) (Day) (Year)

7-AGE, 41 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laundress
(b) General nature of industry, business, or estsblishment in which employed (or employer) ..... Private

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (Stste or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Wallace

(Address) 1315 Brunt St

15- JAN 19 1923 Filed ....., 191.... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 17th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 9th 1922, to Jan 17th 1923, that I saw her alive on Jan 16th 1923, and that death occurred, on the date stated above at 11 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (Duration) 6 yrs. ..... mos. ..... ds.

(Signed) A. Lee Gibson M. D.

1/18, 191.. (Address) 324 Mosher St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, 1—19—1923

20-UNDERTAKER Daniel Easton

ADDRESS 916 Pa Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X146 D71338

D71338

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No.) St Joseph's Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Benton.

(a) RESIDENCE NO. 432 W. Edmondson ST., ... WARD E. B.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ..... ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lloyd A. Benton

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE — Years: 39 — Months: ..... — Days: ..... — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Greenville South Carolina

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Daniel Easton (Address) 916 Pa ave.

15 Filed JAN 19 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to Jan 17, 1923, that I last saw her alive on Jan 17, 1923, and that death occurred, on the date stated above, at 10:10 P. m.

The CAUSE OF DEATH* was as follows:

Placenta Previa

(duration) yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) Puerperal Peritonitis

(duration) yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Geo. W. Waring, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 1-21 1923

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71339

D71339

CERTIFICATE OF DEATH.

144

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 213. N. Schroeder ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Makel

(a) RESIDENCE. No. 213 N. Schroeder ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Makel

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER ? Smith

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER ? Holland

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Husband
(Address) John Makel 213 N. Schroeder

15 Filed JAN 19 1923 ROBERT R. KRAUSE Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1923, to Jan 16, 1923, that I last saw h CY alive on Jan. 16, 1923 and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage

over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Separation of Normally Implanted Placenta

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 16, 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. Norwood Wilson M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	1-19-1923
20 UNDERTAKER Daniel Easton	ADDRESS 716 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D71340

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH D71340

CITY OF BALTIMORE: (No. 2512 Dulaney ST., 20 WARD)

2-FULL NAME Margaret W Michael

(a) RESIDENCE NO. 2512 Dulaney ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Peter M. Michael

6 DATE OF BIRTH (month, day, and year): Jan 21 1838

7 AGE: Years 84 Months 11 Days 28 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED — 020

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Rost

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Veronica Gunda Strauch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Margaret Steinmiller
(Address) 2504 Madison Ave

15 JAN 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 18, 1923, that I last saw h[illegible] alive on Jan 18, 1923, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis Endocarditis Senility

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Roberte Fetch M. D.

(Address) 2151 Hulkin ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: JAN 20 1923

20 UNDERTAKER: J. B. Wyckoff — ADDRESS: 2336 Eutaw ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71341

CERTIFICATE OF DEATH.

44 D71341

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2400 N. Balto ST., 20 WARD)

2-FULL NAME Clemens Jenkins

(a) RESIDENCE NO. 2400 N. Balto ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 30 yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Jenkins

6 DATE OF BIRTH (month, day, and year) Nov 23rd 1869

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
53	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 80

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Russia

14 Informant Anna Jenkins

(Address) 2400 N. Balto St

15 Filed JAN 19 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/17- 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/17- 1923 to 1/17- 1923, that I last saw h[illegible] alive on Jan 17 1923, and that death occurred, on the date stated above, at 5-22 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Chas A Eadline M. D.

1/17, 1923 (Address) 2316 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL JAN 20 1923

20 UNDERTAKER H B Kuykendall

ADDRESS 2236 Fremont Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71342

REGISTERED NO. 90 D71342

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 E. Lanvale ST., 8 WARD)

2-FULL NAME Amelia Black,

(a) RESIDENCE NO. 1705 E. Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Cornelius H. Black

6 DATE OF BIRTH (month, day, and year): Jan. 5, 1831

7 AGE: Years 92 Months -- Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Thurmont Maryland

PARENTS

10 NAME OF FATHER: Henry Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Mary Leatherman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Charles C. Black 742 W. North Ave

15 JAN 19 1923 Registrar: ROBERT R. KRAUTER, Burial Permit Clerk.

16 DATE OF DEATH (month, day, and year): Jan. 17, 1923 2.45 P.M.

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1923, to Jan 13, 1923, that I last saw h alive on Jan 13, 1923, and that death occurred, on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

(Senility)

Arterio Sclerosis

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? all

(Signed) W. Tilley M. D.

(Address) 1628 Bruadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Thurmont, Md.

DATE OF BURIAL: 1/ 20/ 1923

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert St.

IMPORTANT.—AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D71343

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp ST., 25 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Callaha~~n~~ Gosse

(a) RESIDENCE NO. St Agnes Hosp ST., ~~25~~ WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 15-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None MD

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Clement S. Gosse

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Anna Callahan

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs C.S. Gosse
(Address) Catonsville Md

Filed JAN 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1923, to Jan 18, 1923, that I last saw h~~er~~ alive on Jan 18, 1923 and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. A Knells, M. D.

Jan, 1923 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemy

DATE OF BURIAL 1/19 1923

20 UNDERTAKER Henry W. Meas & Son

ADDRESS 805 W. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1604 D71344

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 D71344

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., (W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John K. Miller

(a) RESIDENCE NO. 432 E. Lafayette Ave ST., City WARD Pennsylvania

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 10 mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Lizzie Miller (wife)

6 DATE OF BIRTH (month, day, and year): Sept. 20, 1863.

7 AGE: Years 59 Months 3 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist.

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country): Pa "

PARENTS

10 NAME OF FATHER: Conrad Miller. "

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eliz. Hahn. "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records

15 Filed JAN 19 1923, 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1922, to Jan 18, 1923.

that I last saw him alive on Jan 18, 1923,

and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Oscar R. Bugg M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Pa

DATE OF BURIAL: Jan 20 1923

20 UNDERTAKER: William Bird & Son Nathan

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Lehnert - 928 N. Caroline

Spec.—1-10-21—M&T—1500 Bks.

D71345 HEALTH DEPARTMENT—CITY OF BALTIMORE D71345

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 Holbrook Sl ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George B. Hoggson

(a) RESIDENCE NO. 1422 Holbrook Sl ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Klein

6 DATE OF BIRTH (month, day, and year) Jan 29 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist - Oil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Corn Bldg Co.

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Frank Hoggson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Katie Hoggson (Address) 1422 Holbrook

15 Filed ROBERT R. KRAUTER, Registrar JAN 19 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from July 18 1922, to Jan 18 1923.

that I last saw h[illegible] alive on Jan 18 1923.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Brights Disease

Uremia 11

(duration) 1 yrs., mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis C. Lehnert M. D.

Jan 18 1923 (Address) 928 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 22 1923
20 UNDERTAKER	ADDRESS
H. W. Cole	502 E Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D71346 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D71346

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 906 E. Pratt ST., 3 WARD)

2-FULL NAME Joseph Birkenbach

(a) RESIDENCE NO. 906 E. Pratt ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? unknown

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About 52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): 631

(c) Name of employer: Hooper (Woodbury)

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Louis Birkenbach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Wolbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Alphonse Birkenbach (Address) Frumtar Md

15 Filed JAN 19 1923, 19 ..... Burial Permit Clerk. ROBERT A. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to Jan 17, 1923,

that I last saw him alive on Jan. 17, 1923,

and that death occurred, on the date stated above, at 9:35 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Robert J. Green M. D.

1-18, 1923 (Address) 126 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: Jan 20 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Watts St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. SUSAN JOHNSON

D71347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7th ool D71347

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1545 N. Dulton ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Susan Johnson

(a) RESIDENCE NO. 1545 N. Dulton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. B Johnson

6 DATE OF BIRTH (month, day, and year): Jan 28 1847

7 AGE — Years: 75 — Months: 4 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 031

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Co.

PARENTS

10 NAME OF FATHER: Joseph Coughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Maria Sunderwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Chas B Johnson

(Address): 1545 N Dulton

15 Filed , 19 Registrar

Assist Permit Clerk.

JAN 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/18 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/14, 19 23, to 1/18, 19 23.

that I last saw h alive on , 19 .

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loud Green Md

DATE OF BURIAL: Jan 20 1923

20 UNDERTAKER: Wm Cook

ADDRESS

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Stiplem ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71348 — 38 D71348

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 E Fort ave ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William R Barnes

(a) RESIDENCE. NO. 304 E Fort ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennette Barnes

6 DATE OF BIRTH (month, day, and year) Feb. 27. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
40				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer. 013

(b) General nature of industry, business, or establishment in which employed (or employer) B & O, R R

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll, Co Md

PARENTS

10 NAME OF FATHER Josiah Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll, Co Md

12 MAIDEN NAME OF MOTHER Sarah J Ohler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant (Address) Jennette Barnes 304 E Fort ave

15 FILED JAN 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1923

17 I HEREBY CERTIFY, That I attended deceased from July, 1920, to Jan 16, 1923, that I last saw him alive on Jan 16, 1923, and that death occurred, on the date stated above, at 12 50 p m.

The CAUSE OF DEATH* was as follows:

Tabes Dorsalis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy

(Signed) Wm Kettler, M. D.

1/17, 1923 (Address) 1314 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: 1/19/1923

20 UNDERTAKER: E. J. Fanning & Son — ADDRESS: 1160 Battery Ave.

AFTER FILING SHOULD BE CAREFULLY COPIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71349

CERTIFICATE OF DEATH.

129 D71349

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 830 W. Lombard St. / 18 WARD)

2-FULL NAME Thomas. F. Jones

(a) RESIDENCE NO. 830 W. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or ~~Divorced, (write the word)~~
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma. V. Jones

6 DATE OF BIRTH (month, day, and year) May 23 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	82	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co md

PARENTS

10 NAME OF FATHER Thomas Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co md

12 MAIDEN NAME OF MOTHER Emma. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co md

14 Informant Thomas. C. Jones (Address) Odenton Md

15 JAN 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1923, to Jan 17. 1923.

that I last saw him alive on Jan. 17. 1923.

and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) — yrs. — mos 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinically

(Signed) Thos. Gordon, M. D.

1/18/23 (Address) 888 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	Jan 20 1923
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	217 S. Pan

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71350

CERTIFICATE OF DEATH.

58 D71350

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3508 Norwood Ave. ST. Howard 28 WARD)

2-FULL NAME Mary Theresa Killalea

(a) RESIDENCE NO. 3508 Norwood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Killalea

6 DATE OF BIRTH (month, day, and year) Dec. 15" 1860

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
62	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Mullin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Maher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. George S. Smarden (Address) 3508 Norwood Ave.

15 Filed JAN 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18" 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 13 - 1922, to Jan 18 1923.

that I last saw h.. alive on Jan 17 1923,

and that death occurred, on the date stated above, at 8.15 A m.

The CAUSE OF DEATH* was as follows:

Splenomegaly

Abscess. (duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Bowel disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 7 1

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? blood - etc

(Signed) [signature] M. D.

1/18 1923 (Address) 11 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Jan 20" 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 Park

HEALTH should be correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71351 101-001 D71351

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 E. Lafayette Ave. St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Virginia McAfee

(Residence in Baltimore: No. 103 East Lafayette Ave St.; ....yrs., ...mos. Life ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, January 20th, 1873.
(Month) (Day) (Year)

7-AGE, 50 yrs. 11 mos. 29 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, William L. McAfee

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Caroline Corbell

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ethel M. Anderson

(Address) 103 E. Lafayette Ave.

15- JAN 19 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 18th, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 21st, 1922, to January 18th 1923, that I saw h[illegible] alive on January 18th 1923, and that death occurred, on the date stated above, at 4.20 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(Duration) ....yrs. ....mos. 3 ds.

(Signed) Edgar Stanley Piper M. D.

Jan 18th, 1923. (Address) 1 W Franklin St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park — DATE OF BURIAL, Jan 19, 1923

20-UNDERTAKER C. D. Cook — ADDRESS 1003 Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71352

CERTIFICATE OF DEATH.

101-001 D71352

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2410 Chelsea Terrace ST., 15 WARD)

2-FULL NAME Audrey M. Orwig

(a) RESIDENCE NO. 2410 Chelsea Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 10" 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Walter W. Orwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Alma Pick

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mr. Walter Orwig

(Address) 2410 Chelsea Terrace

15 JAN 19 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18" 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1922 to Jan 18, 1923.

that I last saw h alive on Jan 18, 1923

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary Tuberculosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) Edward K. Faulkner, M. D.

1/19, 1923 (Address) 2724 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Baltyn Md — DATE OF BURIAL 1/20 1923

20 UNDERTAKER Joseph B Cook 1003 — ADDRESS W Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D71353

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D71353

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 E. Shark. ST. 23 WARD)

2-FULL NAME Karl R. Heise

(a) RESIDENCE NO. 1031 E. Shark. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 39 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Heise

6 DATE OF BIRTH (month, day, and year) Mar. 10-1859

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
63	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Hoffstatt Bro's 1914

(c) Name of employer Antique Business

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Heisie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ella Heise
(Address) 1031 E. Shark St.

15 Filed JAN 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Jan 18, 1923, that I last saw h[illegible] alive on Jan 18, 1923 and that death occurred, on the date stated above, at 5.45 ... m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) [illegible] M. D.

Jan 19, 1923 (Address) 835 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery. DATE OF BURIAL Jan 22nd 1923

20 UNDERTAKER Mrs. Mrs John H. Weigle's Son. ADDRESS 801 W. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Most ✓

D71354

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D71354

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 n Potomac ST. 16 WARD)

2-FULL NAME Martha A Mast

(a) RESIDENCE NO. 9 n Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
80		5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland,

PARENTS

10 NAME OF FATHER Joshua Rawlings

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Maria Ireland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Martha Ireland
(Address) 9 N. Potomac St.

15 JAN 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 13 '22 to Jan 17 '23.

that I last saw h alive on Jan 17 1923

and that death occurred, on the date stated above, at 5 00 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) H. Kent Tousley M. D.

(Address) 2458 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 22 1923
20 UNDERTAKER	ADDRESS
Josiah Lyser	1600 W. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D71355

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1213 N Patterson Park Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Almyra Reitz

(a) RESIDENCE. No. 1213 N. Patterson Park Ave ST., 8 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter E Reitz

6 DATE OF BIRTH (month, day, and year) Nov. 4 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
30	30	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER William Oscoinkel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Barbara Donaldson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Walter E Reitz (Address) 1213 N. Patterson Park Ave

15 Filed JAN 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 13 1923 to Jan 18 1923

that I last saw her alive on Jan 18 1923

and that death occurred, on the date stated above, at 10. A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H Herzog M.D. M. D.

1/18. 1923 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan 20 1923
20 UNDERTAKER Henry Lutz	ADDRESS 1203 E Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71356

D71356

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4611 Park Heights St., 5 WARD)

2-FULL NAME Emma Jane Bond

(a) RESIDENCE NO. 4611 Park Heights ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas Bond

6 DATE OF BIRTH (month, day, and year): Feb. 4, 1853

7 AGE: Years 69 Months 3 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: At home

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Wm Pearf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): G. H. Krantz 4611 Park Heights

15 Robert P. Harrison, M. D. Registrar

Burial Permit Clerk.

19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1923, to Jan 18, 1923

that I last saw h[illegible] alive on Jan 18, 1923,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 yrs. mos 11 ds.

CONTRIBUTORY (Secondary): Mitral Insufficiency

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D Seibert M. D.

, 19 (Address) 4854 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: Jan 1923

20 UNDERTAKER: Zorkler & Zorkler

ADDRESS 1734 Eagent

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D71357

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71357

CERTIFICATE OF DEATH.

38

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. [illegible] WARD)

2-FULL NAME Conrad Hettchen

(a) RESIDENCE NO. 400 S. 14th St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm. Hettchen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Alsdorf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records. (Address)

15 Filed 1/19/1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from December 4, 1922, to January 18, 1923, that I last saw him alive on January 17, 1923, and that death occurred, on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:

Angina pectoris

Unknown (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ? Syphilitic myocarditis. (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Wasserman.

(Signed) H. Hurdon ... M. D.

11/18/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Jan 20 1923

20 UNDERTAKER John Leerich

ADDRESS 200 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71358

CERTIFICATE OF DEATH.

D71358

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 30 S. Potomac ST., 1 WARD)

2-FULL NAME Clara A. Rechter

(a) RESIDENCE NO. 30 S. Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: August Rechter

6 DATE OF BIRTH (month, day, and year): Jan. 16 1873

7 AGE: Years 50; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. J.

PARENTS

10 NAME OF FATHER: Curran

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER: Sophia Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. J.

14 Informant: August Rechter

(Address): 30 S Potomac St

15 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk

19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1923

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923 to Jan 18, 1923

that I last saw h alive on Jan 17, 1923

and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John K. Owen, M. D.

Jan 19 23 (Address) 35 W Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Millville, N. J.

DATE OF BURIAL: 1/20/1923

20 UNDERTAKER: J. A. Moran

ADDRESS 3000 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71359

CERTIFICATE OF DEATH.

4 161-00 D71359

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Braun #1.

(a) RESIDENCE. No. ..... St., Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male-	White	[illegible]

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of [illegible]

6 DATE OF BIRTH (month, day, and year) Jan. 17-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ½ hrs. or min.
			37 hrs.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. H. Balto. Md.

PARENTS

10 NAME OF FATHER Frank Borman-

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mildred Braun.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Belair, Md-

14 Informant
(Address)

1923 Robert F. Harrison
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 17 - , 1923, to Jan 18 , 1923, that I last saw h[illegible] alive on Jan 18 , 1923, and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Twin Pregnancy -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Anthony V Buchanan, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71360

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71360

CERTIFICATE OF DEATH.

4161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. University Hospital ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Braun #2

(a) RESIDENCE. NO..... ST., WARD. ..

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Infant Jan. 17-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1/4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. H. Balto. Md.

PARENTS

10 NAME OF FATHER Frank Burman

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Mildred Braun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Belair, Md.

14 Informant (Address) Mildred Braun Belair, Md

15 Filed 19 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17 1923, to Jan. 18 1923.

that I last saw him alive on Jan 18 1923.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Twin pregnancy -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Anthony V. Bruhn M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL JUL 5 1923 Commissioner of Health, Per. Wm. R. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spmc.—6-3-19—H. P. Co.—1000 Blks.

D71361

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71361

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2242 E Fairmount Ave ST.: 6 WARD)

2-FULL NAME Francis Ching

(a) RESIDENCE. NO. 2242 E Fairmount Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Mongolian (Chinese)	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 23-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Yee Gam Ching

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canton China.

12 MAIDEN NAME OF MOTHER Yee Sue Ngon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canton China.

11 Informant (Address)

15 Filed . 19 Registrar

JAN 19 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23 . 1922 to January 19 1923

that I last saw her alive on Jan 19 . 1923.

and (hat death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity (7 months)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocardial degeneration.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What (est confirmed diagnosis?

(Signed) W. G. Geyer M. D.

. 19 (Address) 541 N. Mettonave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19 JAN 19 1923
20 UNDERTAKER Commissioner Health.	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

160980.
D74362

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 101-09 D71362

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 9 WARD)

2-FULL NAME Mrs. Annie Elizabeth Paul.

(a) RESIDENCE NO. Frederick Junction, Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~WIFE of~~: Miss Ruby Paul (daughter)

6 DATE OF BIRTH (month, day, and year): ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): " 037

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Penn.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: JOHNS HOPKINS HOSPITAL.
(Address) Boards.

15 JAN 19 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan' 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1923, to Jan 19 1923, that I last saw her alive on Jan 19, 1923, and that death occurred, on the date stated above, at 9¼ A.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Frederick, Md.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) Bateman, M. D.

1-19, 1923 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Frederick Md — DATE OF BURIAL: Jan 19 1923

20 UNDERTAKER: Geo J Smith — ADDRESS: Baltimore

JAN 19 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71363

CERTIFICATE OF DEATH.

90

REGISTERED NO.

D71363

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2839 Wallbrook Ave 15 (WARD)

2-FULL NAME Geo. M. Bowersox

(a) RESIDENCE No. 2839 Wallbrook Ave. WARD

(Usual place of abode) (If non-resideot give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 12 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	77	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John M. Bowersox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lydia Wolfinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informan Mrs Lester Wallace

(Address) 2839 Wallbrook Ave

15 Filed Robert P. Harrison, Registrar

19 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1922, to Jan 18, 1923,

that I last saw him alive on Dec 24, 1922

and that death occurred, on the date stated above, at 10 Eve P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Leonard E Black M. D.

19 (Address) 2231 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Jan 19 1923

20 UNDERTAKER George J Smith — ADDRESS 1623 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71364

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 409 Park Ave St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leon Rasst

(Residence in Baltimore: No. 409 Park Ave St.; yrs. 4 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. July 17, 1866 (Month) (Day) 1..... (Year)

7-AGE.	If LESS than 1 day,
56 yrs. 6 mos. 1 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Russia

PARENTS:

10-NAME OF FATHER, Boris Moses

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER, Rebecca----------

13-BIRTHPLACE OF MOTHER, (State or Country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Helen Markowitz

(Address) 2600 Creston Ave, N. Y. City

15- Robert P. Harrison

Filed ..... 192..... Burial Permit Clerk. Registrar.

JAN 19 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 18 (Day) 1923 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au~~ topsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Chronic

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J K Fenneche M. D.

1-19 1923 (Coroner.) (Address) 117 W Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Druid Ridge Cemetery	1/20/23 19

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 Calvert St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D71365

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71365

CERTIFICATE OF DEATH.

X 188-003

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Johnson

(Residence in Baltimore: No. 612 Parrish St.; yrs. (1) mos.) ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH. unknown ....., 1..... (Month) (Day) (Year)

7-AGE. 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Common

9-BIRTHPLACE, (State or Country): Washington D C

PARENTS.

10-NAME OF FATHER, Johnson

11-BIRTHPLACE OF FATHER, (State or Country). Virginia

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Washington D C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Johnson

(Address) 5 Champagne Pl. N.E.

15- Robert P. Harrison,

Filed ..... 192..... Burial Permit Clerk. Registrar.

19 1923

N. B.—Every item of information should be carefully supplied. AGE should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 18 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Compound Fracture of Tibia & Fibula, Auto accident while riding in automobile (Duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) Deficiency of blood accident (Duration) ..... yrs. ..... mos. 4h ds.

(Signed) James H. Benton M. D. (Coroner)

Jan. 19 1923 (Address) 701 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) In the
At place of death ..... yrs. ..... mos. 20 ds. State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Cor Carrollton Ave & Mulberry & (Washington) 612 Parrish St.

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Washington D C — DATE OF BURIAL: Jan 19 1923

20-UNDERTAKER, Samuel Hensley — ADDRESS Kidd

(Renner)

D71366 HEALTH DEPARTMENT—CITY OF BALTIMORE D71366

188-003

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH Renner and a

City of BALTIMORE: (No. St. Josephs Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Irene Renner

(Residence in Baltimore: No. 1125 Madison Ave St.; yrs. 18 mos. 6 ds. 18)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Female	White	Married

6-DATE OF BIRTH. June (Month) 28 (Day) 1894 (Year)

7-AGE. 28 yrs. 6 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto. Md

PARENTS

10-NAME OF FATHER. Chas W. Hawkins

11-BIRTHPLACE OF FATHER. (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Mary A. Birmingham

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Hawkins

(Address) 1125 Madison Ave

15- Robert P. Harrison, 192.....

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 17 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an examination (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Automobile collision

Fractured Skull - Chest injuries (Contusions)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) D. yrs. ....mos. ....ds.

(Signed) J. Ed. Calvert M. D. (Coroner)

1-18 1923 (Address) 518 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL. Jan 20/ 1923

20-UNDERTAKER. W. W. Gaither ADDRESS 2837 Rayner Ave

N 1 1923

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D71367

HEALTH DEPARTMENT--CITY OF BALTIMORE

D71367

CERTIFICATE OF DEATH

100-001

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3216 Eastern Ave St.; 16 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Born

(Residence in Baltimore: No. 3216 Eastern Ave St.; 4 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX F.

4-COLOR OR RACE W.

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Widow

6-DATE OF BIRTH May (Month) 12 (Day), 1844 (Year)

7-AGE 78 yrs. 8 mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work None. Retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Germany

PARENTS

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Henry Fink

(Address) 3216 Eastern Ave

15 Robert P. Harrison, ..., 191

Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Jan. (Month) 18 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1922, to Jan. 18 1923.

that I saw her alive on Jan 17, 1923.

and that death occurred, on the date stated above, at 1 30 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... yrs. ..... mos. 2 ds

Contributory (SECONDARY) Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 20 ds.

(Signed) Frank A. Glantz M. D.

Jan 19, 1923 (Address) 3244 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Jan 21, 1923

20-UNDERTAKER Peter Nicolaus ADDRESS 2060 Easter

B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

No 19 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71368

D71368

X 143-103

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

2-FULL NAME Lucy Gordon.

(a) RESIDENCE NO. Catonsville Md ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Gordon.

6 DATE OF BIRTH (month, day, and year) Sept. 5. 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	4	14.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER James Rowan

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Martha Mull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hosp Records

(Address) .....

15 Filed ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1923, to Jan 19, 1923.

that I last saw her alive on Jan 19, 1923

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

Broncho

(duration) ..... yrs. ..... mos 9 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of 1-17-23

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. J. Strong M. D.

....., 19 ..... (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockey Mount. N. C.

DATE OF BURIAL 1/19 1923

20 UNDERTAKER H. L. Watzke

ADDRESS .....

N 20 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71369

D71369

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 Norwood Ave 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Horseman

(a) RESIDENCE NO. 1732 Norwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George H Horseman

6 DATE OF BIRTH (month, day, and year): Nov. 4/1866

7 AGE — Years: 56 Months: 2 Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Somerset Co Md

PARENTS

10 NAME OF FATHER: Joseph L. C. Veta

11 BIRTHPLACE OF FATHER (city or town) (State or country): Somerset Co Md

12 MAIDEN NAME OF MOTHER: Sarah A Webster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Somerset Co Md

14 Informant: George H Horseman

(Address): 1732 Norwood Ave

Filed 1923 Robert P. Harrison, Registrar

Silver 3706 Liberty Heights Ave

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1920 to Jan 18th 1923, that I last saw her alive on Jan. 18th 1923, and that death occurred, on the date stated above, at 5.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Howard C. Silver, M. D.

, 19 (Address) 3706 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dear Island Md — DATE OF BURIAL: Jan 20 1923

20 UNDERTAKER: Williamback — ADDRESS: 926 E Nathan

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71370 D71370

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 609 E. 35th ST., 9 WARD)

2-FULL NAME James P. Curran

(a) RESIDENCE NO. 609 E. 35th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Theresa B. Curran

6 DATE OF BIRTH (month, day, and year): Dec 25-1867

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
55	-	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Motorman

(b) General nature of industry, business, or establishment in which employed (or employer): 878

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Curran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget McCahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Elin. Curran

(Address) 609 E. 35th St.

15 Robert P. Harrison, Registrar

.19

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1923, to Jan 19 1923.

that I last saw him alive on Jan 18, 1923,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Lemon Paral

Tuesday (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

.19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Govans — DATE OF BURIAL: Jan. 22 1923

20 UNDERTAKER: W. C. Warfield — ADDRESS: 914 Drummond Ave

No 20 1923

BEFORE SHOULD be Carefully Supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71371

CERTIFICATE OF DEATH.

91-002 D71371

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Little Sisters of the Poor ST. 10 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Boyce

(a) RESIDENCE. NO. 6 Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow of

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ezekiel Boyce

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md. U.S.A.

PARENTS

10 NAME OF FATHER Edward Mitchell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) —

12 MAIDEN NAME OF MOTHER Emelia Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Sr. Florence, Asst. St. Jacennah
(Address) Preston & Valley Sts. Robert T. Harrison,

15 JAN 20 1923 . 19 Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Novem 19 to . 19 ,

that I last saw h 20 alive on . 19 ,

and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

Jany 19 23 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Jan. 20 1923

20 UNDERTAKER: N. C. Wiedefeld — ADDRESS: 91 Grmmt. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Scaramazzi)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71372 10 D71372

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 613 N. Collington ST., 7 WARD)

2. FULL NAME Nicholas Scaramazzo

(a) RESIDENCE NO. 613 N. Collington Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 14 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Bach

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 11-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Emilio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Bianca Meinelli

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mother (Address) 613 N. Collington Ave

15 Robert F. Harrison, Registrar

Filed N 2 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Jan 18, 1923, that I last saw h[illegible] alive on Jan 19, 1923, and that death occurred, on the date stated above, at 1.50 p. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical & Lab findings

(Signed) Nicholas J. Lombardi, M. D.

, 19 (Address) 232 S. High St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL 1-20 1923

20 UNDERTAKER David Easton

ADDRESS 916 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71373

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D71373

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 Carlton ST. 11 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cassie Parker

(a) RESIDENCE NO. 225 N Carlton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced (~~HUSBAND~~ of) (or) WIFE of: Harry Parker

6 DATE OF BIRTH (month, day, and year): March 23, 1880

7 AGE: Years 42 Months 9 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Eddie Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Eleanor Hopcon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Harry Parker

(Address) 225 N Carlton St.

15 Robert P. Harrison, 19

Burial Permit Clerk Registrar

20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 18, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1922 to Jany 18, 1923.

that I last saw her alive on Jany 18, 1923.

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Valvulitis

Indeterminable ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) Indeterminate ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) W. A. Howell M. D.

(Address) 1119 N Carrollton Ave 1/19/1923

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

D71374

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71374

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 908 Sarah ann st, 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm J. Morgan

(Residence in Baltimore: No. 908 Sarah ann st St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col	Widower

6-DATE OF BIRTH. Dont Know (Month) (Day) (Year)

7-AGE. 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Dont Know

11-BIRTHPLACE OF FATHER, (State or Country). " "

12-MAIDEN NAME OF MOTHER. " "

13-BIRTHPLACE OF MOTHER, (State or Country). " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Es Platee

(Address) 211 S. Parish

15- Robert F. Harrison, Registrar.

JAN 4 1923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan (Month) 17 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or Inquiry.~~ thereon and from the evidence obtained by said ~~Inquest, au~~ find that said deceased came to ~~his~~ death ~~topsy or Inquiry.~~ on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis from Mother Dont Kn

(Duration) yrs. Dont Kn ds.

(Signed) W. K. Gorman M. D. (Coroner.)

1-19 1923 (Address) 117 W Lanvale St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Cem DATE OF BURIAL. Jan 19th 1923

20-UNDERTAKER. A. Jones ADDRESS. 111 S Gilmor St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

160895
D71375

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D71375

1-PLACE OF DEATH

CITY OF BALTIMORE: No. JOHNS HOPKINS HOSPITAL ST., H WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Jones

(a) RESIDENCE No. 1135 Etting St. City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July ?

7 AGE: Years 36 | Months ? | Days ? | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Henry Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 Filed Robert P. Harrison Registrar

Burial Permit Clerk.

20 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 11 , 1923 , to Jan 18 , 1923 , that I last saw her alive on January 18, 1923, and that death occurred, on the date stated above, at 3 23 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Peritoneal tuberculosis - Tuberculosis of liver & rectum, with tuberculous stricture of rectum. (duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary embolism —

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Jan-11-1923

Was there an autopsy? Yes

What test confirmed diagnosis? Yes - Autopsy.

(Signed) Wayne E. Cox M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL Jan 22 1923

20 UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Bks.

D71376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71376

CERTIFICATE OF DEATH.

X92

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Womans Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louise Lepp

(a) RESIDENCE NO. Finksburg R F D ST., WARD Finksburg Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 hrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emory C Lepp

6 DATE OF BIRTH (month, day, and year) Aug 9, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Wm N. Schelling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Brothers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Wm Schelling (Address) Finksburg

15 Filed JAN 20 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1923, to Jan 18, 1923, that I last saw her alive on Jan 18, 1923, and that death occurred, on the date stated above, at 6.45 p.m.

The CAUSE OF DEATH* was as follows:

Mesenteric Thrombosis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Examination.

(Signed) Norman E. Tannenbaum M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md.

DATE OF BURIAL Jan 20 1923

20 UNDERTAKER W. M. Routson

ADDRESS 2238 N Howard

JAN 20 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Zasada)

D71377

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71377

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 S. Bethel ST. 3 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Zasada

(a) RESIDENCE No. 611 S. Bethel ST., 3 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 30 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Vincent Zasada

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Mary Zienski

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Mary Zasada
(Address) 611 S Bond

15 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 18 1923

17 I HEREBY CERTIFY, That I attended deceased from December 11, 1923, to January 17, 1923, that I last saw him alive on January 17, 1923, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

marasmus

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Indigestion

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? [illegible]

(Signed) [illegible], M. D.

1-19-1923 (Address) 722 S. Ann st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Jan 20 1923

20 UNDERTAKER: Johnson & Ober — ADDRESS: 1803 Bank st

JAN 20 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Intestinal

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71378

D71378

31

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 849 Washington Blvd ST.; 11 WARD)

2-FULL NAME Kajetonas ~~Stanburys~~ Gaubris

(a) RESIDENCE. NO. 849 Washington Blvd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of not known

6 DATE OF BIRTH (month, day, and year) ~~March~~ 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

880

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Agnes Gaubis
(Address) 662 Portland st

15 Filed Jan 20 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1920, to Jan. 19, 1923, that I last saw him alive on Jan. 18, 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis with Tumor Albus of the left leg

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Disease Chronic Valvular Heart (duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronusas, M. D.

1-19-1923 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan. 22 1923
20 UNDERTAKER	ADDRESS
John Grebliunas	425 S. Paca St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 20 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71379 D71379

CERTIFICATE OF DEATH.

111-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Pulziano

(a) RESIDENCE NO. 1304 E. Pratt St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	37	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Emidio Pulziano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Municipal Hospital Records. (Address)

15 Robert F. Harrison, Registrar

Burial Permit Clerk.

JAN 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16 1923

17

I HEREBY CERTIFY, That I attended deceased from December 17, 1922, to January 16, 1923.

that I last saw him alive on January 16, 1923.

and that death occurred, on the date stated above, at 12:05 P.M.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage from stomach (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Refused Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

1/17/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincents

DATE OF BURIAL Jan 20th 1923

20 UNDERTAKER Wendel Pippelow

ADDRESS 374 Conn

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71380

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71380

CERTIFICATE OF DEATH.

100-001

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC
TION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3102 W Donnell ST., 1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane McClintock

(a) RESIDENCE NO. 3102 W Donnell ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George McClintock

6 DATE OF BIRTH (month, day, and year) Oct 31 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	2	18	

8 OCCUPATION OF DECEASED Housewife

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) not known Ireland

PARENTS

10 NAME OF FATHER John Doyle

11 BIRTHPLACE OF FATHER (city or town) not known (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) not known (State or country) Not known

14 Informant Robert McClintock
(Address) 4203 Ashland Ave Beyond

15 Filed Jan 20 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1922, to Jan 18, 1923,

that I last saw h[illegible] alive on Jan 17, 1923,

and that death occurred, on the date stated above, at 11 30 M m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope (a)
asphyxia.

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. W. Wright, M. D.

1/19, 1923 (Address) 1014 S. Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem. DATE OF BURIAL Jan 26 1923

20 UNDERTAKER H. Sander & Sons ADDRESS 1210 Pine

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71381

D71381

44

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 621 S. Lakewood Ave ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Maynard

(a) RESIDENCE. No. 621 S. Lakewood ST. 1, WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of James R. Maynard

6 DATE OF BIRTH (month, day, and year) Oct 18 - 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Hunderdieten Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Dora Buddemeyer (Address) 621 S. Lakewood Ave.

15 Filed N 20 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 . 1922 . to July 15 . 1923 . that I last saw alive on July 15 . 1923 . and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Long, M. D.

1-16 1923 (Address) 210 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Jan. 20 1923
20 UNDERTAKER	ADDRESS
N. Sander & Sons.	1710 Eutaw St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71382

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71382

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 814 S Ehrdaye ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Gross

(a) RESIDENCE. NO. 814 S Ehrdaye ST. 22 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benj. Gross.

6 DATE OF BIRTH (month, day, and year): April 1857

7 AGE — Years: 65 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Sam Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Bessie Brown (Address) 114 S Sharp St

15 Filed , 19 Robert F. Harrison, Registrar

201923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/18/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/16/ 1923, to 1/18/ 1923, that I last saw h alive on 1/18/ 1923, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Jay Bowley, M. D.

1/18/ 1923 (Address) 905 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — Jan 21 1923

20 UNDERTAKER: John H. Trodden

ADDRESS 142 Utica St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71383

100-001

D71383

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 S. Robinson St. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Bennett

(a) RESIDENCE NO. 317 S. Robinson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John C. Bennett.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nora Sparks.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) John Lesser Bennett. (R.) 317 S. Robinson St.

15 Filed Robert F. Hartsock Burial Permit Clerk JAN 20 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from 18 Jan. 1923. to 18 Jan. 1923. that I last saw h alive on 18 Jan. 1923, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. T. Mother M. D.

, 19 (Address) 301 S Ellwood Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz's Cem.

DATE OF BURIAL Jan. 20 1923.

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Mo[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71384

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71384

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery & Child's Hosp ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Miranda

(a) RESIDENCE No. Nursery & Child's Hosp ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? —yrs. —mos. —ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Baby —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec - 8 - 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Baby —

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore - Md.

PARENTS

10 NAME OF FATHER Salvatore Miranda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Blanche Ruhm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant (Address) C. Marquis 1101 E. Monument St

15 Filed ....., 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1922, to Jan - 20 - 1923 -

that I last saw her alive on Jan — 14, 1923 —

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Indigestion

(duration) yrs. 1 mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas L. Pringle M. D.

, 19 (Address) 702 E. Balt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	JAN 20 19 23
20 UNDERTAKER	ADDRESS
G. B. Warfield & Son	2316 Eutaw Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

201923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71385 D71385

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1625 Orleans ST., 6 WARD)

2-FULL NAME Herman Diggs

(a) RESIDENCE NO. 1625 Orleans ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	14	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Herman Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Barrie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lonnie Jackson (Address) 1625 Orleans St

15 Filed ... Registrar

Robert P. Harrison, Burial Permit Clerk.

201923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1923, to Jan. 18, 1923.

that I last saw him alive on Jan. 1, 1923,

and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Subacute bronchitis

(duration) ... yrs. 1 ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Robinson M. D.

1/19, 1923 (Address) 1520 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leakin Park DATE OF BURIAL Jan. 22 1923

20 UNDERTAKER Theo. E. White ADDRESS 1131 Mallory

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71386

CERTIFICATE OF DEATH.

145-003

D71386

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2862 Harford ave St. 9 WARD)

2-FULL NAME Mrs Ella E. Scarborough

(a) RESIDENCE. No. 2862 Harford ST. 9 WARD. 9

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or Divorced (write the word)
Female	W.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Gilbert Scarborough

6 DATE OF BIRTH (month, day, and year) Jan. 7 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) Balto. md

PARENTS

10 NAME OF FATHER Milto C. Brundige

11 BIRTHPLACE OF FATHER (city or town). (State or country) Balto. md

12 MAIDEN NAME OF MOTHER Anna Ruth

13 BIRTHPLACE OF MOTHER (city or town). (State or country) Balto.

14 Informant Wm. J. Scarborough (Address) 2862 Harford ave

15 Filed JAN 20 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1923. to Jan 18, 1923.

that I last saw h.er alive on Jan 18, 1923.

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilitation

over

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary) Confinement

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M. D.

Jan 19, 1923 Address) 2752 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 20 1923

20 UNDERTAKER F. A. Krause & Son ADDRESS 733 Hanover

Please sign in carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71387

CERTIFICATE OF DEATH.

90 ✓ D71387

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Simmons

(a) RESIDENCE No. 1047 S. Charles St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER B.T. Thomas

11 BIRTHPLACE OF FATHER (city or town) Eastern Shore, (State or country) Maryland

12 MAIDEN NAME OF MOTHER S.E. Cook

13 BIRTHPLACE OF MOTHER (city or town) Eastern Shore (State or country) Maryland

14 Informant Municipal Hospital Records. (Address)

15 JAN 20 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from January 18, 1923 to January 19, 1923, that I last saw her alive on January 18, 1923, and that death occurred, on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Terminal Bronchopneumonia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? A- 1047 S. Charles

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [signature] M. D.

1/19/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden DATE OF BURIAL Jan 22 1923

20 UNDERTAKER Chenoweth & Son ADDRESS Chestnut Ave

Notice should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71388

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71388

CERTIFICATE OF DEATH.

101-00

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Elsa Carter

(~~Residence in Baltimore: No.~~ Reisterstown Md St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) M

6-DATE OF BIRTH. Dec 6 1922
(Month) (Day) (Year)

7-AGE. yrs. 1 mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, George Carter

11-BIRTHPLACE OF FATHER. (State or Country). Montgomery Co Md

12-MAIDEN NAME OF MOTHER, Mary Zahn

13-BIRTHPLACE OF MOTHER, (State or Country). Carroll Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Zahn Carter

(Address) Reisterstown Md

15-

Filed 1923

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 19 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

I. Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Cullen M. D.
(Coroner.)

1-20 1923 (Address) 1427 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Zion Cemetery Westminster Md. DATE OF BURIAL. Jan 21 1923

20-UNDERTAKER, Mrs Mary Zahn Carter (Mother) ADDRESS (Reisterstown Md)

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of is very important. See instructions on back of certificate.

20 1923

Mrs Mary Jane Carter
Registered Nurse

Mrs. Carter
Wants permit to
get the body.

Geo H Greer

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71389 D71389

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2023 Oak St. ST., 17 WARD)

2-FULL NAME James E Baskins

(a) RESIDENCE NO. 2023 Oak St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): 1922

7 AGE: Years 6 Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Edward Baskins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lottie Baskins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): born in Ind

14 Informant: Mother Lottie Baskins
(Address): 2023 Oak St

15 JAN 20 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1923, to Jan 18, 1923.

That I last saw him alive on Jan 17, 1923,

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) x yrs. x mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) x yrs. x mos. 12 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Cecil Hall, M. D.

. 19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Jan 20 1923

20 UNDERTAKER: Mrs Robert A Elliott — ADDRESS: 1726 Eastland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71390

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 D71390

CERTIFICATE OF DEATH.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp ST. 17 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James E. Green

(Residence in Baltimore: No. 3294 E. 23 St.; yrs., 19 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Col	S.

6-DATE OF BIRTH, May (Month) 23 (Day) 1909 (Year)

7-AGE, ... yrs. 7 mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Thomas Green

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Emma Booker

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. Green

(Address) 3294 E. 23

15- Filed JAN 20 1928 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 18 (Day), 1928 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns general accident
received from stove

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. J. Riley M. D.
(Coroner.)

Jan 20, 1928 (Address) 1637 Druid

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Jan 20, 1928

20-UNDERTAKER, H W R R T Elliott — ADDRESS 1735 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71391 X 99 D71391

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 South Grey ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ramseyer (RAMSEYER)

(Residence in Baltimore: No. Triumph Mill Road, Rosville St.; ....yrs., 1 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6 DATE OF BIRTH (month, day, and year) April 26th 1878

7 AGE: Years 44; Months 8; Days 21; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS.

10-NAME OF FATHER Louis Smith

11-BIRTHPLACE OF FATHER (State or Country) Balto. Maryland

12-MAIDEN NAME OF MOTHER Mary Shellion

13-BIRTHPLACE OF MOTHER (State or Country) Balto. Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Lena Ramseyer

(Address) Rosville Md.

15-

JAN 20 1923 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 17th, 1923.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 11th 1923, to January 17th 1923, that I saw h[illegible] alive on January 17th 1923, and that death occurred, on the date stated above, at 4.20 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ....yrs. 7 mos. ....ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) ....yrs. ....mos. 1 ds.

(Signed) W. H. Duncan Parran M. D.

January 19, 1923. (Address) 1 W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Rosville Md.

19-PLACE OF BURIAL OR REMOVAL, Immanuel Cemetery

DATE OF BURIAL, Jan. 21, 1923

20-UNDERTAKER Fred'k Lovash & Sons

ADDRESS Baltimore

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71392

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71392

CERTIFICATE OF DEATH.

231

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 N. Caroline ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Marie Holmes

(a) RESIDENCE No. 1210 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. Holmes

6 DATE OF BIRTH (month, day, and year): Nov. 26th 1901

7 AGE — Years: 21 — Months: 1 — Days: 21 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Kent Co. Maryland

PARENTS

10 NAME OF FATHER: Edward Moffett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent Co. Maryland

12 MAIDEN NAME OF MOTHER: Minnie Keating

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co. Maryland

14 Informant: Mrs Mamie Endres

(Address): 1201 E. Caroline St.

15 Filed 19 Robert P. Harris

Registrar

Burial Permit Clerk.

201923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 2 1922 to Jan 17 1923, that I last saw h alive on Jan 17 1923, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) B T Kelly M. D.

19 (Address) 100 N Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick Cassatt Holy

DATE OF BURIAL: Jan 22 1923

20 UNDERTAKER: Holy Redeemer Cemetery

ADDRESS: Ft Avenue

Spec.—1-10-21—M&T—1500 Bks.

D71393

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D71393

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 N. Stricker ST., 19 WARD)

2-FULL NAME Margaret E. Zeigler

(a) RESIDENCE NO. 212 N. Stricker ST., 19 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Samuel R. Wesdon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Q. A. Co. Md

12 MAIDEN NAME OF MOTHER: Emma T. Nicholas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Margaret Gernhardt

(Address): 212 N. Stricker

15 Robert F. Morrison, 19 Registrar

Burial Permit Clerk.

N 201923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/19/23 19

17 I HEREBY CERTIFY, That I attended deceased from 12/24/22, 19 , to 1/19/23, 19 ,

(that I last saw h.. alive on 1/19/23, 19 ,

and that death occurred, on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Chr. Ad. Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) F. W. Miller, M. D.

1/20, 19 23 (Address) 1202 Ford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 1/23 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 5021 York

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71394

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71394

CERTIFICATE OF DEATH.

164

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2608 Riggs av. ST., 16 WARD)

2-FULL NAME Elizabeth Tarrant

(a) RESIDENCE NO. 2608 Riggs av. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Tarrant

6 DATE OF BIRTH (month, day, and year) Unknown 1845

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John J Vance

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Letetia Shadden

(Address) 907 N. Bentalou

15 Filed ..... , 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1923 to Jan 19th 1923.

that I last saw her alive on Jan 11th 1923

and that death occurred, on the date stated above, at about 3 P. M.

The CAUSE OF DEATH* was as follows: old age

Hypostatic Lungs (Had Pneumonia

10 or 12 yrs ago)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hiram F. Wann, M. D.

, 19 (Address) 833 N Fulton av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 1/22 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E North

201923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71395

CERTIFICATE OF DEATH. X100-001

D71395

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline LcConte Gibbes.

(a) RESIDENCE No. Fensel Hall, Md. Av-23-St. ST., 12 WARD (Columbia, S.C.)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 20 yrs. 0 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (----NONE----)

6 DATE OF BIRTH (month, day, and year) Jan-4-1903.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student at the

(b) General nature of industry, business, or establishment in which employed (or employer) Goucher College

(c) Name of employer Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country) Columbia, S.C.

PARENTS

10 NAME OF FATHER A. Mason Gibbes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Columbia S.C.

12 MAIDEN NAME OF MOTHER Caroline LeConte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Columbia, S.C.

14 Informant JOHNS HOPKINS HOSPITAL & (Address) Mrs. C. L. Gibbes, Columbia, S.C.

15 Robert P. Harrison, Registrar

N 2 01929

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1923, to Jan 20, 1923,

that I last saw her alive on Jan. 20, 1923,

and that death occurred, on the date stated above, at 2 32 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) Wetherman, M. D.

1-20, 1923 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Columbia, S.C. DATE OF BURIAL: Jan-20-23

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

K0514
D71396

HEALTH DEPARTMENT—CITY OF BALTIMORE

103

D71396

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., W WARD)

2-FULL NAME Martha Harb

(a) RESIDENCE NO. 704 S. Bethel St. City ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Edward Harb. (Husband)

6 DATE OF BIRTH (month, day, and year): Feb. 2, 1900.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
22	11	17.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: H. W.
(b) General nature of industry, business, or establishment in which employed (or employer): (H)
(c) Name of employer: (H)

9 BIRTHPLACE (city or town) (State or country): (H) Maryland

PARENTS
10 NAME OF FATHER: Adam Bell
11 BIRTHPLACE OF FATHER (city or town) (State or country): (H) Ireland
12 MAIDEN NAME OF MOTHER: Mary Klynarch
13 BIRTHPLACE OF MOTHER (city or town) (State or country): (H) Ireland

14 Informant's (Address): JOHNS HOPKINS HOSPITAL. Records

15 Filed ....., 19 .....
Robert P. Harrison, Registrar
Burial Permit Clerk

N 201923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26 1922 to Jan 19 1923, that I last saw her alive on Jan 19 1923, and that death occurred, on the date stated above, at 12 15 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary): Pulmonary Infarction

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas R Bunce, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus. Cem.
DATE OF BURIAL: Jan. 22 1923.

20 UNDERTAKER: M. F. Sadowski
ADDRESS: 905 S. Ann St

Mail information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

60908
D71397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 44 ✓ D71397

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo. Pacy

(a) RESIDENCE NO. 314 E. 84th St. N.Y.C. ST., ... WARD ..... New York N.Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17

7 AGE — Years: 49 — Months: 1 — Days: 2 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hotel Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

609

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER Faustido Pacy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER Julia Razzle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records

15 Filed ... Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1923 to Jan 19, 1923.

that I last saw him alive on Jan 19, 1923,

and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
Followed by Bilateral pneumonia
and myocardial failure

(duration) 1 yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 16

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Myron E. Goldblatt, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmell — DATE OF BURIAL: Jan 20 1923

20 UNDERTAKER: Joseph Abrens — ADDRESS: 22 Bway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

20 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

V 71398

X 159-001

D71398

(1-998) D71398 398

REGISTERED NO. D71398

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cofield

(a) RESIDENCE NO. 54 Bunce St S. Manchester, Conn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Aug 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	5	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Conn

PARENTS

10 NAME OF FATHER Joseph Cofield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn

12 MAIDEN NAME OF MOTHER Amy Tremaglia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 JAN 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20- 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1922, to Jan 20, 1923, that I last saw h alive on Jan 20, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus — Obstruction Congenital

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home Dec 1. 1922

Did an operation precede death? Yes Date of Dec 31 1922 Jan 20 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) [illegible], M.D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glastonbury Conn Buried Cash (Over)

DATE OF BURIAL Jan 21 1923

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 Bway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Telephone Connection

Lady Assistant

FRANK M. LOWE

438 Main Street

FUNERAL DIRECTOR and EMBALMER

#31

Glastonbury, Conn., January 24 1923

C. Hampson Jones M. D.
Commissioner of Health

Dear Sir;

On Transit Permit for William Cofeill Jan 20 was Distination Hartford Conn although it was to be in transit to Glastonbury Conn. I changed it to read Glastonbury Conn so will you make note of same on your record?

Respectfully Yours

Frank M. Lowe

JAN 26 1923

let Dr. Jones see original records

Spec.—1-10-21—M&T—1500 Bks.

71399 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 71399

D71399 CERTIFICATE OF DEATH. 90 D71399

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1840 Presstman ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellenora Bankard

(a) RESIDENCE No. 1840 Presstman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of, (or) ~~WIFE~~ of: Widow of Thomas E Bankard

6 DATE OF BIRTH (month, day and year): Nov. 14 1828

7 AGE: Years 95 Months 2 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co Md

PARENTS

10 NAME OF FATHER: Daniel Eyler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Md

12 MAIDEN NAME OF MOTHER: Elizabeth Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Charles H Garrison (Address) 1840 Presstman

15 JAN 21 1923 Filed ..., 19 ROBERT R. KRAUTER, Registrar ..... Clerk.

Transcribed 12/19/98 sfa

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1922 to Jan 20, 1923, that I last saw her alive on Jan 19, 1923 and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs, acute
Congestion

(duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) General Senility

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam

(Signed) John A Bratton M. D.

Jan 20, 1923 (Address) 1219 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Linwood Md

DATE OF BURIAL: Jan 22 1923

20 UNDERTAKER: William Lee

ADDRESS: 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. D71400

71400

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Mrs Gilroy 622 N. North

907140 D71400

REGISTERED NO. D71400

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 419 Pinkney St. 14th WARD)

2-FULL NAME Caroline Smith

(a) RESIDENCE No. 419 Pinkney Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced (or) WIFE of Henry Smith

6 DATE OF BIRTH (month, day, and year) May 6-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Adam Piffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Leah Nepp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Laura V. Ulse

(Address) 419 Pinkney Place

15 Filed JAN 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923, to June 19, 1923, that I last saw h alive on June 18, 1923, and that death occurred, on the date stated above, at 9.15 a m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H S Gray, M. D.

1/20, 1923 (Address) 627 W Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery DATE OF BURIAL 1/22 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E. North

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71401

CERTIFICATE OF DEATH.

-14-001 D71401

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2326 Reisterstown Rd. ST. 15 WARD)

2-FULL NAME Max H. Schumacher

(a) RESIDENCE. NO. 2326 Reisterstown Road ST.... WARD....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hazel S. Schumacher

6 DATE OF BIRTH (month, day, and year) July 17 68

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Optician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Henry Schumacher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Schmoll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Hazel S. Schumacher (Address) 2326 Reisterstown Rd

15 Filed JAN 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1923, to Jan 19, 1923, that I last saw him alive on Jan 18, 1923, and that death occurred, on the date stated above, at 1210 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophic Chronic Nephritis yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of ?

Was there an autopsy? no

What test confirmed diagnosis? Pulse, Bp

(Signed) F. Ken Williams M. D.

, 19 (Address) 601 Carroll Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 23 1923
20 UNDERTAKER	ADDRESS
W. M. Coulson	2230 N. Howard St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71402 D71402

CERTIFICATE OF DEATH.

REGISTERED NO. 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2911 Chelsea Ter ST., 15 WARD)

2-FULL NAME Elizabeth Snyder

(a) RESIDENCE NO. 2911 Chelsea ST., WARD

(Usual place of abode) (If non-resident give city or town and State) Ohio

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Wm S Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Evangride

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Wm S Snyder

(Address) 2911 Chelsea Terrace

15 JAN 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1923, to Jan 20, 1923, that I last saw h alive on Jan 20, 1923 and that death occurred, on the date stated above, at 8.45 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.

, 19 (Address) 101 N. Carey.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chester Pa.

DATE OF BURIAL: Jan 22 1923

20 UNDERTAKER: H M Rowson

ADDRESS: 2235 N Arlington

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16099 D71403
Ped.

31 D71403

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.) (Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Howard

(a) RESIDENCE No. 1736 Ashland Ave (City) St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr. 23 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Hall Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elsie Wilmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: JOHNS HOPKINS HOSPITAL, Records

(Address)

15 Filed JAN 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1923, to Jan 18, 1923, that I last saw him alive on Jan. 18, 1923, and that death occurred, on the date stated above, at 6.40 A.m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

Tuberculous Meningitis

(duration) — yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) — yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of — — —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Evergreen Cem. — DATE OF BURIAL: Jan. 24 1923

20 UNDERTAKER: Thos J. S. Locks — ADDRESS: 1312 Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Toffp. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71404

CERTIFICATE OF DEATH.

129 D71404

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1528 Hanover ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Toffe

(a) RESIDENCE NO. 1528 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William F Toffe

6 DATE OF BIRTH (month, day, and year) Feb 2 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or....min.
	70	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Christian Toffe

11 BIRTHPLACE OF FATHER (City or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Christ

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Mrs Charles E. Burns

(Address) 1528 Hanover St

15 JAN 21 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1922, to Jan 19, 1923, that I last saw h[illegible] alive on Jan 19, 1923, and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

about (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) Sam Hochheimer M. D.

Jan 20 1923 (Address) 1412 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL Jan 25 1923

20 UNDERTAKER E. Wildman Son

ADDRESS 1034 Lanvale

mation should be carefully supplied. AGE should be stated EXACTLY. FIGURES should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71405 ✓ x84 D71405

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl [illegible] Echols

(a) RESIDENCE NO. Parkersburg W. Va ST., WARD Wood

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Mrs. Hazel Echols

6 DATE OF BIRTH (month, day, and year): Sept 11 1887

7 AGE: Years 35; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): D 31

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): W. Va

PARENTS

10 NAME OF FATHER: Samuel P Echols

11 BIRTHPLACE OF FATHER (city or town) (State or country): W Va

12 MAIDEN NAME OF MOTHER: Mary G Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va

14 JOHNS HOPKINS HOSPITAL. Informant (Address)

15 JAN 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Jan 20, 1923

that I last saw him alive on Jan 20, 1923

and that death occurred, on the date stated above, at 8 10 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor, cerebellar glioma

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Jan 20 23

Was there an autopsy? Yes (Partial)

What test confirmed diagnosis? Operation

(Signed) F. H. Baldwin, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkersburg W. Va. DATE OF BURIAL: Jan. 21 1923

20 UNDERTAKER: Wm C. Black ADDRESS: 927 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 D71406

D71406

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 N. Streeper ST., 4 WARD)

2-FULL NAME Evelyn M. Lambdin

(a) RESIDENCE NO. 504 N. Streeper ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9-22

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Albert F. Lambdin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Antonette Hulka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Albert F. Lambdin (Address) 504 N. Streeper

15 Filed JAN 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/19 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to Jan. 19, 1923, that I last saw her alive on Jan. 18, 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Pressmen, M. D.

1.20.23. 19 (Address) Dew Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 1/14 1923

20 UNDERTAKER Philip Hennig

ADDRESS 2016 Orleans

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71407

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71407

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joe Hannik (Havranek)

(a) RESIDENCE No. St. Joseph's Hosp ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
66				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant St. Joseph Hospital

(Address) Baltimore

15 JAN 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1923, to Jan. 20, 1923.

that I last saw him alive on Jan. 20, 1923

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma cardia and ? Stomach

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S.A.S.

(Signed) J. J. Kraus, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Jan 22 1923

20 UNDERTAKER Frank Graeber

ADDRESS 1006 York Ave

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71408 31 D71408

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1275 Catherine St. 20 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara S. Saffran

(a) RESIDENCE. No. 1275 S. Catherine St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Geo. J. Saffran

6 DATE OF BIRTH (month, day, and year) October 13 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Joshua Houck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah R. Gayley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant S. Edw. Saffran

(Address) 1275 Catherine St

15 Filed JAN 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Jan 20, 1923, that I last saw her alive on Jan 19, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robert C Fulton, M. D.

JAN 20 1923, 19 (Address) 3151 Hillsdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Western

DATE OF BURIAL JAN 23 1923

20 UNDERTAKER Geo W Little

ADDRESS 3760 EDMONDSON AVE.

D71409 HEALTH DEPARTMENT—CITY OF BALTIMORE D71409

CERTIFICATE OF DEATH.

REGISTERED No. C .....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 27 ST., WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick C Seyler

(Residence in Baltimore: No. 314 Belvedere Ave. St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, ... Jan. (Month) 10 (Day), 1888 (Year)

7-AGE, 35 yrs. 9 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer) ..... P.R.R.

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Chas A. Seyler

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna C. Hand Rachel

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs F C. Seyler
(Address) 314 Belvedere

15- FILED JAN 21 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan 19/23 (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Vertebra - Injury to Spinal Cord Internal injuries
Dead from being struck by R.R. freight car & Crushing
when Caught between cars & Crushing Chest (minutes
Duration) Instant (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Concussion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
Jan 21, 1923 (Address) 10 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Woodlawn	Jan 22, 1923

20-UNDERTAKER Horace A. Burgee ADDRESS 3331 Falls Rd

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D71410 HEALTH DEPARTMENT—CITY OF BALTIMORE D71410

CERTIFICATE OF DEATH. 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 N. Fulton Ave. WARD 16)

2-FULL NAME Evelyn Mae Adams

(a) RESIDENCE NO. 722 N. Fulton Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or ~~Divorced.~~ (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 24 1921

7 AGE: Years 1 | Months 1 | Days — | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lawrence W. Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dyden N. York

12 MAIDEN NAME OF MOTHER Mildred L. Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Lawrence W. Adams (Address) 722 N. Fulton Ave.

15 JAN 21 1923 ROBERT W. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1923, to Jan 19, 1923, that I last saw her alive on Jan 19, 1923, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Croupous Pneumonia

"Lobar"

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard S. Levitt, M. D.

1/20, 1923 (Address) 1707 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL: Jan 22 1923

20 UNDERTAKER: Jos Joerdens & Son ADDRESS 2173 Pac

NOTE.—WRITE LEGIBLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71411

CERTIFICATE OF DEATH.

X 44

D71411

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James P. Rittenhouse

(a) RESIDENCE NO. Mt. Winans 2nd ST., WARD Mt Winans Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. 2 mos. (4) ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Rittenhouse

6 DATE OF BIRTH (month, day, and year) Nov 15 1850

7 AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or .. min.
	72	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co.

PARENTS

10 NAME OF FATHER Charles Rittenhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Amelia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Charles C. Rittenhouse

(Address) Spence & Worrell Rds

15 Filed JAN 21 1923 19..... ROBERT R. KRANTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from January 9, 1923, to January 19, 1923, that I last saw him alive on January 19, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

1. Gastric Carcinoma

(duration) (unknown) yrs. mos ds.

CONTRIBUTORY (Secondary) 1. Lobar pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes. Date of Jan 12-1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operation

(Signed) James Hubert Jefferson M. D.

19 (Address) Md General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan. 22 1923
20 UNDERTAKER	ADDRESS
John C. Mitchell	120 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71412

CERTIFICATE OF DEATH.

129

D71412

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1400 Eutaw Place ST. 14 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Brennan Lamb

(a) RESIDENCE. NO. 1400 Eutaw Place ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George M. Lamb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ann Woodward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Anna E. Brown

(Address) 1400 Eutaw Place

15 Filed JAN 21 1923 . 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22 . 1922 . to Jan. 19 . 1923.

that I last saw h alive on Jan. 18 . 1923.

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis.

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No. Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Physical examination and tests

(Signed) Charles Hes, M. D.

Jan 21, 1923 (Address) 1111 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mound	Jany 22 1923

20 UNDERTAKER Wm. O. Mitchell & Son ADDRESS 8 N. Fayette St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71413

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. S. W. Cor Park ave & Mulberry st St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Chin Kuk Jack

(Residence in Baltimore: No. S. W. Cor Park ave & Mulberry sts St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Chinese

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Feby 14 Don't Know 1864
(Month) (Day) (Year)

7-AGE. 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laundry
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country) China

PARENTS.

10-NAME OF FATHER. Don't Know

11-BIRTHPLACE OF FATHER. (State or Country) " "

12-MAIDEN NAME OF MOTHER. China

13-BIRTHPLACE OF MOTHER. (State or Country) Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chin Luong

(Address) 114 Park Ave

15-

Filed JAN 21 1923 ROBERT R. KRAUSE

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan 18 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or~~ Inquiry.)

thereon and from the evidence obtained by said ~~Inquest, au~~

find that said deceased came to ~~topsy or Inquiry.)~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably La Grippe

(Duration) yrs. mos. ds.

(Signed) M. K. Goldstein M. D.
(Coroner)

1-18 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery DATE OF BURIAL. Jany 22 1923

20-UNDERTAKER. John O. Mitchell ADDRESS 1200 W. Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71414

CERTIFICATE OF DEATH.

X 16-001

D71414

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 1 WARD)

2-FULL NAME Jennie Broughton

(a) RESIDENCE NO. Perryville ST., Maryland WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 Wks How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William H. Broughton

6 DATE OF BIRTH (month, day, and year): June 18-1853

7 AGE — Years: 69 Months: 7 Days: 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cecil Co Md

PARENTS

10 NAME OF FATHER: Thomas Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Delilah Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs R. A. Smith (Address) Perryville Md

15 Filed JAN 21 1923 ROBERT P. KRAUTZ Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 20 1923

17 I HEREBY CERTIFY, That I attended deceased from December 23, 1923 to January 20, 1923.

that I last saw her alive on January 20, 1923, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Amoebic Dysentery

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) James Hubert Wilkerson M.D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Perryville Cecil Co

DATE OF BURIAL: 1/23 1923

20 UNDERTAKER: William Cook

ADDRESS: 502 E North Ave

D71415

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D71415

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3409 Fremont St. 12 WARD) (If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George F Volandt

(Residence in Baltimore: No. 3409 Fremont Ave St.: 54 yrs. mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: 12 (Month) 25 (Day), 1868 (Year)

7 AGE: 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: News Office
(b) General nature of industry, business, or establishment in which employed (or employer): Reporter

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William F. Volandt

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret White

13 BIRTHPLACE OF MOTHER (State or country): England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Volandt
(Address) 3409 Fremont ave

15
Filed JAN 2 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 19 (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922 to Jan 19 1923
that I saw h alive on Jan 19, 1923
and that death occurred, on the date stated above, at 8 0 m.
The CAUSE OF DEATH* was as follows:

Metast Malignancy of heart and Hypertrophy of Liver (Duration) 2 yrs. mos. ds

Contributory (SECONDARY) arteriosclerosis (Duration) 5 yrs. mos. ds.

(Signed) Geo Schmidt Jr M. D.
Jan 20, 1923 (Address) 6 E. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Baltimore
DATE OF BURIAL: Jan 22, 1923

20 UNDERTAKER: William Cook
ADDRESS: 502 E Monument

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71416 D71416

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 506 W Fayette St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Franz Joseph Muller

(Residence in Baltimore: No. 506 W Fayette St.; yrs. 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: July (Month) 26 (Day) 1868 (Year)

7-AGE: 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Baker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Austria

PARENTS.

10-NAME OF FATHER: Dont Know

11-BIRTHPLACE OF FATHER, (State or Country): ~~~

12-MAIDEN NAME OF MOTHER: ~~~

13-BIRTHPLACE OF MOTHER, (State or Country): ~~~

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frd Friedman

(Address) 5 E Monument

15- Filed JAN 21 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 20 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

from History

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H K Gorsuch M. D.
(Coroner.)

1-21 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: Jan 23 1923

20-UNDERTAKER: Wm Oak ADDRESS 5 E Monument

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71417

D71417

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 25 WARD)

2-FULL NAME Aubrey E. Cost.

(a) RESIDENCE NO. 4th & Edison St. Brooklyn, MD ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mildred L. Cost.

6 DATE OF BIRTH (month, day, and year) June 3- 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~34~~	34	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad Yard Master.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Virginia.

PARENTS

10 NAME OF FATHER Thomas Cost

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Martha Yeakey.

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Virginia.

14 Informant Mrs Mildred Cost (Address) Brooklyn Md.

15 Filed JAN 21 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1923

17

I HEREBY CERTIFY, That I attended deceased from December 27, 1922, to January 19, 1923, that I last saw him alive on January 19, 1923, and that death occurred, on the date stated above, at 10.40 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of mediastinum with metastases to liver.

(duration) yrs. 4 mos. 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) P.B. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Jan 22 1923

20 UNDERTAKER Wm J Tickner & Son ADDRESS N. Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71418 D71418

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2139 Mt Holly ST. 15 WARD)

2-FULL NAME Louise Dekenkel Jones

(a) RESIDENCE NO. 2139 Mt. Holly ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alonzo F. Jones

6 DATE OF BIRTH (month, day, and year): May 24, 1845

7 AGE — Years: 77 — Months: 7 — Days: 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Philipp Dekenkel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Helen Rangulie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lewis D. Jones

(Address) 2139 Mt Holly ST

15 JAN 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21 1923

17 I HEREBY CERTIFY That I attended deceased from Dec- 6, 1922, to Dec- 21, 1923,

that I last saw h~~e~~r alive on Dec 20, 1923,

and that death occurred, on the date stated above, at 3.15 9 m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

Complicating bronchitis.

and Cardiac dilatation

(duration) — yrs. mos 14 ds.

CONTRIBUTORY (Secondary): Myocarditis-chronic

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?: —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J Wesley Cole, M. D.

1/21, 1923 (Address) 2202 Garrison.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Jan 22 1923

20 UNDERTAKER: Wm Hickner & Sons

ADDRESS North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71419

CERTIFICATE OF DEATH.

11-001 ✓ D71419

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2741 W North St., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Granger Sr.

(a) RESIDENCE NO. 2741 W. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maggie E. Granger.

6 DATE OF BIRTH (month, day, and year): June 15-1853

7 AGE: Years 69 Months 7 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: machinist.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: H. Clem & Sons. 031

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Thomas Granger.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rachel Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Eugene E. Granger

(Address) 2741 W. North Ave

15 Filed JAN 21 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 19 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1923, to Jan. 19, 1923

that I last saw him alive on Jan. 18, 1923

and that death occurred, on the date stated above, at 2.00 a. m.

The CAUSE OF DEATH* was as follows:

Ia Grippe.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Clem M. D.

1/19/23 (Address) 2757 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Jan 22 1923

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

Spec.—1-10-21—M&T—1500 Bks.

D71420

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D71420

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 653 Light ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Ringer

(a) RESIDENCE NO. 653 Light St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Edward L. Ringer

6 DATE OF BIRTH (month, day, and year) Feb 14 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Geo. W. Hadaway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan McClain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Edward L. Ringer (Address) 653 Light St

15 JAN 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1922, to Jan. 18, 1923

that I last saw her alive on Jan 18, 1923

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Le Grippe, Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mary Cook Willis, M. D.

1-19-1923 (Address) 710 Hamilton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boonsboro Washington Co. Md

DATE OF BURIAL Jan 22 1923

20 UNDERTAKER Via Auto

ADDRESS 715 Light St

John F. Denny

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71421

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-0 D71421

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3 Lewiston ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Joseph Kenneth Fanow

(a) RESIDENCE NO. 3 Lewiston ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lft yrs. mos. ds. How long in U. S., if of foreign birth Lft yrs. mos. ds.

(If non-residents give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 16 1922

7 AGE: Years 1 Months Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Arthur Fanow

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Ellis Rill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Arthur Fanow

(Address) 3 Lewiston ave

15 JAN 21 1923

ROBERT P. KRAUSE

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1923, to January 19, 1923,

that I last saw him alive on January 19, 1923

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hill M. D.

, 19 (Address) Physician Reisterstown Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pauls Arcadia Md DATE OF BURIAL: Jan 22 1923

20 UNDERTAKER: Wilhamb ADDRESS: 5120 Park Ave

NOTE—PARENTS, AUTHORIZED OFFICIALS AND PHYSICIANS ARE REQUIRED TO SUPPLY THE INFORMATION CALLED FOR BY THIS CERTIFICATE. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71422

CERTIFICATE OF DEATH.

114 D71422

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 N. Stricker ST., 16 WARD)

2-FULL NAME James W. Powell

(a) RESIDENCE NO. 1118 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Martha A. Powell

6 DATE OF BIRTH (month, day, and year) Oct. 4th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of Industry, business, or establishment in which employed (or employer) Gen'l Painting

(c) Name of employer Jas. Neal Georgetown Va

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Jno. W. Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME Catharine McKelvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs Nasola A. Powell 1118 N. Stricker St

15 JAN 21 1923 ROBERT P. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 1922, to Jany 21st, 1923, that I last saw him alive on Jany 20, 1923, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Chronic Diarrhoea

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Granular Nephritis & Wasting

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Vesybee

(Signed) [illegible] M. D.

1923 (Address) 1605 Montpelier

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Jan 23 1923

UNDERTAKER William Lee ADDRESS 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

71423

HEALTH DEPARTMENT—CITY OF BALTIMORE

71423 D71423

CERTIFICATE OF DEATH.

X 23

D71423 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (STREET OR WARD)

2-FULL NAME Roy [redacted] Farley

(a) RESIDENCE NO. 804 Hollins ST., WARD Pipestem, W.Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 4 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 25, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dental Student

(b) General nature of industry, business, or establishment in which employed (or employer) Teaching Institution

(c) Name of employer Univ. Dental, Balto, Md.

9 BIRTHPLACE (city or town) (State or country) Pipestem, W.Va.

PARENTS

10 NAME OF FATHER Will O. Farley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pipestem, W.Va.

12 MAIDEN NAME OF MOTHER Lina Farley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Farley, W.Va.

14 Informant B. J. Grodsund (Address) Pipestem W.Va.

15 JAN 21 1923 ROBERT R. KRAUTER, (Registrar) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1923, to Jan. 21, 1923.

that I last saw him alive on Jan. 21, 1923,

and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH* was as follows:

Diffuse Meningeal Encephalitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Respiratory Apoplexia. Partial Ptosis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? Yes. Was there anatomic confirmation? Autopsy

What test confirmed diagnosis?

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pipestem W. Va. DATE OF BURIAL Jan 22 1923

20 UNDERTAKER F H Witzke ADDRESS 15 31 Ferdinand St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

71424 HEALTH DEPARTMENT—CITY OF BALTIMORE 71424

D71424
(PLACE OF DEATH)

CERTIFICATE OF DEATH.

1880-00 D71424
REGISTERED NO. C

CITY OF BALTIMORE (No. Homewood Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ferdinand Wolfarth

(Residence in Baltimore: No. 2124 Ramsay St. 40 Yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX. M

4 COLOR OR RACE W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH April 16, 1869
(Month) (Day) (Year)

7 AGE. 53 yrs. 9 mos. 3 ds.

If LESS than 1 day, hrs. or min.

8 OCCUPATION (a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) City

9 BIRTHPLACE (State or Country) Germany

PARENTS.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or Country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

(Informant) Amy Fr. Wolfarth

2124 2726 Ramsay St. (Address)

15 Filed JAN 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk. (DI)

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH Jan 20, 1923
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries from Auto Accident

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) John Thomsen M. D. (Coroner)

Jan 21, 1923 (Address) 5132 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. To the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL London Park Cem. DATE OF BURIAL Jan 22, 1923

20 UNDERTAKER C. W. Dill. ADDRESS 3109 Fredk. Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Eagle.

D71425

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71425

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. 7 ST., North WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Daniel Eagle.

(a) RESIDENCE NO. Statesville South Carolina ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 26. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): 54

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N.C.

PARENTS

10 NAME OF FATHER Sterling P. Eagle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Missouri

12 MAIDEN NAME OF MOTHER Edith Watt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.C.

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 FILED JAN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1922, to Jan. 22, 1923, that I last saw h alive on Jan. 22, 1923, and that death occurred, on the date stated above, at 12 44 a. m.

The CAUSE OF DEATH* was as follows:

Abscess of Liver

(duration) yrs. mos 2 0 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes. Date of 1-8-23.

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test.

(Signed) Watt Norman, M. D.

1-22, 1923 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Statesville N C — DATE OF BURIAL: Jan 22, 23

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 224 Bway

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71426

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71426

CERTIFICATE OF DEATH.

100-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 530 So. Ann St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. James R. Baker Jr

(Residence in Baltimore: No. 530 So. Ann St.; yrs...mos...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Sept (Month) 4 (Day) 1922 (Year)

7-AGE. — yrs. 4 mos. 16 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Ch
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto. md

PARENTS.

10-NAME OF FATHER. James R. Baker Sr

11-BIRTHPLACE OF FATHER. (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER. Dorothy Durdle

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James R. Baker Sr

(Address) 530 So. Ann St

15- Filed JAN 22 1923 192... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan (Month) 20 (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ...yrs. ...mos. ...ds.

(Signed) Thos B. Norton M. D. (Coroner)

Jan 21 1923 (Address) Curtis Bay, Balto, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death...yrs...mos...ds. In the State...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Sacred Heart Cemetery. DATE OF BURIAL. Jan. 23 1923

20-UNDERTAKER. George F. Ruth ADDRESS 1735 Harford ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71427 — 1-PLACE OF DEATH

D71427 — REGISTERED NO.

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Thomas E. Snyder

(a) RESIDENCE. NO. Mt Hope Retreat ST., 28 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 0 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10 / 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	23	(	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer

(b) General nature of industry, business, or establishment in which employed (or employer) Packing - 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Thomas E Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Mary Francy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland (?)

14 Informant Records of Mt Hope (Address) Mt Hope md

15 Filed JAN 22 1923 ROBERT P. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 13 , 1917 , to Jan 19th , 1923 , that I last saw him alive on Jan 19 , 1923 , and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Epelepsy

abt (duration) 4 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Status Epelepticus

abt (duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery , M. D.

Jan 19 , 1923 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 22 1923

20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Harford Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71428

CERTIFICATE OF DEATH.

90 D71428

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1527 N. Mount ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Burr

(a) RESIDENCE. No. 1527 N. Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Wm. G. Burr

6 DATE OF BIRTH (month, day, and year) Jan. 30, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore County, Md.

PARENTS

10 NAME OF FATHER Richard Grant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore County Md.

12 MAIDEN NAME OF MOTHER Ellen Beade.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County Md.

14 Informant Hilda Burr (Address) 1527 N. Mount St.

15 JAN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18, 1923

17 I HEREBY CERTIFY, that I attended deceased from Dec. 27, 1922, to Jan. 16, 1923, that I last saw he alive on Jan. 16, 1923, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) John D. Quinn, M. D.

1/18, 1923 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Jan 22 1923

20 UNDERTAKER James H. Dennis, Treasurer ADDRESS 1303

Notice should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Streib

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

D71429

D71429

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3027 Strickland ST., 20 WARD)

2-FULL NAME Catherine Streib.

(a) RESIDENCE NO. 3027 Strickland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of George Scheuler

6 DATE OF BIRTH (month, day, and year) May 7, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town)t (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant George Scheuler

(Address) 3027 Strickland St

15 JAN 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1923, to Jan 20, 1923,

that I last saw her alive on Jan. 19, 1923,

and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis 10 Yr

Acute Bronchitis 10 day

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edward V. Cockeham, M. D.

, 19 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westerns Cem

DATE OF BURIAL Jan 22 1923

20 UNDERTAKER Mr & Mrs John W. Trufel & Son

ADDRESS 801 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71430

CERTIFICATE OF DEATH.

57 D71430

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospt ST., 19 WARD)

2-FULL NAME Wm J Elliott

(a) RESIDENCE NO. 203 S Gilmore St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ...min.
	60	7	10.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Elliott

11 BIRTHPLACE OF FATHER (city or town) Ireland,
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Johnston

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland,

14 Informant Edward Elliott
(Address) 203 S. Gilmore

15 JAN 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/18/23 19

17 I HEREBY CERTIFY, That I attended deceased from 1/16/23, 19..., to 1/18/23, 19...,
that I last saw h.. alive on 1/18/23, 19...,
and that death occurred, on the date stated above, at 6.40 P m.

The CAUSE OF DEATH* was as follows:
Diabetic Pulitis

(duration) 1 yrs mos ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene of Pulmonary Arteriosclerosis yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Symptoms
(Signed) Jno A Sothoron M. D.
, 19 (Address) Md Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Jan. 22 19 23

20 UNDERTAKER Harry J Weitzke

ADDRESS 1531 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Blks.

D71431

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71431

+139

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Woman's Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Markillie Ross

(a) RESIDENCE NO. Clarion. Pa. ST., WARD Clarion Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. ds. How long in U. S., if of foreign birth? 71 yrs. 0 mos. 0 ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. Frank Ross

6 DATE OF BIRTH (month, day, and year): Oct 22, 1851

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	2	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Horse work.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: John Markillie

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Lucinda Bishop

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mr. A. B. Stuart (Address) 203 Oakdale Rd.

15 JAN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1923, to Jan 21, 1923, that I last saw h.er alive on Jan 21, 1923, and that death occurred, on the date stated above, at 1.20 p.m.

The CAUSE OF DEATH* was as follows:

Toxic myocarditis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Pyometra

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 8, 1923

Was there an autopsy? No.

What test confirmed diagnosis? Physical findings

(Signed) Norman E. Taumenbaum M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Clarion Pa

DATE OF BURIAL: 1-22 1923

20 UNDERTAKER: Howard Jenkins & Sons Co

ADDRESS: Hillcrest Orchard

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation: Jan 8, 1923.
Panhysterectomy
Bilateral salpingo-oophorectomy
Diagnosis - Myoma uteri
Pyometra

D71432

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D71432

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 717 Bradley St. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mildred Johnson

(Residence in Baltimore: No. 717 Bradley St. St.; yrs. 11 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Feb. 4 1922
(Month) (Day) (Year)

7-AGE. yrs. 11 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). Infant

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER. Milton Johnson

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER. Eva Brown

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Eva Johnson

(Address) 717 Bradley St.

15- FILED JAN 22 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan. 19 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Was history of any infection or contagious disease

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Jan. 21 1923 (Address) 2702 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Carmel Cem

DATE OF BURIAL. 1-20 1923

20-UNDERTAKER. David Easter

ADDRESS 716 Balto

INSTRUCTIONS: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10

REGISTERED NO. D71433

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 N. Montford Ave ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna M. Shaney

(a) RESIDENCE NO. 124 N. Montford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 9, 1921

7 AGE — Years: 1 — Months: 3 — Days: 12 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William R. Shaney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Boston Mass

12 MAIDEN NAME OF MOTHER: Margaret Zick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: William R. Shaney

(Address) 124 N. Montford Ave

15 JAN 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1923

17

I HEREBY CERTIFY, That I attended deceased from June 19, 1923, to Jan 21, 1923; that I last saw h alive on Jan 21, 1923 and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos 5 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home Knows

Did an operation precede death? Intubation Date of Jan 19, 23

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Meyer Ephraim M. D.

, 19 (Address) 1904 E Bolt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: Jan 22 1923

20 UNDERTAKER: H. Vander & Sons — ADDRESS: 1710 Fleet St

Spec.—1-10-21—M&T—1500 Bks.

160484 4 29 p.m. D71434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-012

D71434

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Schilling

(a) RESIDENCE No. 3804 E. Coast St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): July 22 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Henry Schilling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Adelia Erkeberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 Date JAN 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 23 - 1922, to Jan 20 1923,

that I last saw him alive on Jan 20 - 1923,

and that death occurred, on the date stated above, at 4 20 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) yrs. mos. (3) ds.

CONTRIBUTORY (Secondary) Otitis media, suppurative

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis M. D.

1/21/1923 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: Jan 22 1923

20 UNDERTAKER: H. Sander Sons

ADDRESS: 1710 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71435 HEALTH DEPARTMENT—CITY OF BALTIMORE D71435

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 S. Montford Ave ST., 1 WARD)

2-FULL NAME Katherine Kimmerle

(a) RESIDENCE NO. 618 S. Montford Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ Widowed (3-22-23) C.S.H.

5a If married, widowed, or divorced ~~HUSBAND of~~ (the late) WIFE of: Bernhard Kimmerle

6 DATE OF BIRTH (month, day, and year): March 25. 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	79	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Jacob Sauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: George Kimmerle

(Address): 618 S. Montford ave

15 JAN 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21 1923

I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1921, to Jan. 21, 1923,

that I last saw her alive on Jan. 21, 1923,

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. D. Kerr, M. D.

1/22/1923 (Address) 407 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cemetery — DATE OF BURIAL: Jan 24 1923

20 UNDERTAKER: A. Sander & Sons — ADDRESS: 1710 East St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T - 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71436

CERTIFICATE OF DEATH.

31 D71436

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) Municipal Tuberculosis Hospital ST., 17 WARD)

2-FULL NAME Lawrence Wheeler

(a) RESIDENCE NO. 1532 Division st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bellhop

(b) General nature of Industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer Caswell Hotel

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Noah Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14

Informant Hospital Records

(Address) M.T.H.

15

Filed JAN 22 1923 19...

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1922, to Jan. 17, 1923,

that I last saw him alive on Jan. 17, 1923,

and that death occurred, on the date stated above, at 12.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. L. Lehaplace, M. D.

1-17, 1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jackson N.C.

DATE OF BURIAL Jan 22 1923

20 UNDERTAKER John H Owens

ADDRESS 517 Druid Hill Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

Mariam R. Cross

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71437

CERTIFICATE OF DEATH.

185

D71437

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 908 N. Calvert (St.:) 11th (WARD)

2-FULL NAME Mariam Ramsay Cross (Mrs. Andrew Boyd)

(a) RESIDENCE. NO. 908 N. Calvert St ST., 11th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

1.15 on Jan 20/23

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rev Andrew B. Cross

6 DATE OF BIRTH (month, day, and year) Don't know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85.	Don't Know	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co. Md.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jefferson D Ramsay

11 BIRTHPLACE OF FATHER (city or town) Norfolk
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mariam M Conley

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant John B Ramsay Jr
(Address) 20 E. Eager St.

15 JAN 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20 1923

17 I HEREBY CERTIFY, That I attended deceased from December 28, 1922, to January 20, 1923.

that I last saw h[illegible] alive on January 19, 1923.

and that death occurred, on the date stated above at 1.15 a m.

The CAUSE OF DEATH* was as follows:

Senility, with Chronic Bronchitis & non-tuberculous

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Traumatism, by fall

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Mary Mead Dran, M. D.

, 19 (Address) 901 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Jan 22 1923

20 UNDERTAKER: John B. Spence — ADDRESS: 1525 N. Caroline St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71438

D71438
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Registered No. C.....

City of BALTIMORE: (No. 711 S. Fremont St. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Edw Lee

(Residence in Baltimore: No. 711 S. Fremont St St.; yrs. 72 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col

5-Single, Married, Widowed or Divorced, (Write the word.): Sngle

6-DATE OF BIRTH: March (Month) 11 (Day) 1922 (Year)

7-AGE: ....yrs. 10 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nom
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: Luther Lee

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary Langford

13-BIRTHPLACE OF MOTHER, (State or Country): Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Wilson

(Address) 711 S. Fremont St

15-
Filed JAN 22 1923 192
JESSE R. KRAUTER,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 19 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

....(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Whooping Cough

....(Duration) ....yrs. 2 mos. ....ds.

(Signed) .... M. D. (Coroner.)

1/20 1923 (Address) 717 W. Saratoga St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Pt Lookout Cemetery

DATE OF BURIAL: 1/22 1923

20-UNDERTAKER: Jno Scott Hooper

ADDRESS: 701 W Saratoga St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71439

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D71439

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 673 Sarah Ann ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Whalen

(a) RESIDENCE NO. 673 Sarahan n ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male.	COLOR.	SINGLE.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) APRIL. 9. 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work LABOR.

(b) General nature of industry, business, or establishment in which employed (or employer) NO

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) BALTI. MD.

PARENTS

10 NAME OF FATHER JIM. WHALEN.

11 BIRTHPLACE OF FATHER (city or town) MD.
(State or country)

12 MAIDEN NAME OF MOTHER mary. mitchell

13 BIRTHPLACE OF MOTHER (city or town) md.
(State or country)

14 Informant leonard. whalen.
(Address) 67 3. SARAHANN. ST

15 Filed JAN 22 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1923. to Jan. 19, 1923.

that I last saw him alive on Jan. 19, 1923.

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Pulmonary)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

, 19 (Address) 1118 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL 1/23 1923

20 UNDERTAKER R. L. PARHAM ADDRESS 220 Hunterary st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71440

CERTIFICATE OF DEATH.

X 143-003

D71440

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin) Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Zirkin

(a) RESIDENCE NO. New Freedom Ave ST., WARD New Freedom Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Zirkin

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abram Rosenblum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1434 Ensor St

15 FILED JAN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-21- 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1923, to Jan 21, 1923, that I last saw her alive on Jan 21, 1923 and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Ruptured tubal Pregnancy

I saw deceased

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Synovial Sarcoma of Tongue

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-18-23

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Winston L. Carr, M. D.

1/21, 1923 (Address) Franklin Sq Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL Jan 22 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1434 Ensor St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71441

D71441

CERTIFICATE OF DEATH.

REGISTERED NO. 162

1-PLACE OF DEATH St. Agnes Hosp-

CITY OF BALTIMORE: (No. ..... ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Dorris Talley.

(a) RESIDENCE NO. Loudon Park ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Wh-	Infant-

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
			15-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant-

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Earl Talley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Fringgling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Earl Talley (Address) Loudon Park

15 Filed JAN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21. 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-21-, 1923, to 1-21-, 1923, that I last saw her alive on 1-21-, 1923, and that death occurred, on the date stated above, at 3 45 a m.

The CAUSE OF DEATH* was as follows:

Peritonitis (Secondary to Infection of cord)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No-

What test confirmed diagnosis? Clinical

(Signed) Tod Caldwell, M. D.

, 19 (Address) #85-73.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 23rd, 1923
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Fredk. Ave;

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71442

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 16 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Henry

(Residence in Baltimore: No. Mercy Hospital St.; yrs. ..... mos. 1 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH, about (Month) (Day) 1857 (Year)

7-AGE, about 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Seaman
(b) General nature of Industry, business, or establishment in which employed (or employer). Fireman SS

9-BIRTHPLACE, (State or Country), Jamaica

PARENTS:

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Norwegian Vice Consulate

(Address) 12 South Street

15- Filed JAN 22 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 21, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (Coma) about

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yr. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Jan. 22 1923 (Address) 2 East Lanvale St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Jamaica

19-PLACE OF BURIAL OR REMOVAL, Loud cemetery DATE OF BURIAL, Jan. 22, 1923

20-UNDERTAKER, Robt J. Turner Jr. ADDRESS 1412 N. Broadway

STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH D71443

County

Registration Dist. No. 100 D71443

Village or City (No. 1906, Fleet St; 7 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Dorothy May Helen Norris

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	X

6 DATE OF BIRTH: July (Month) 17th (Day), 1922 (Year)

7 AGE: ....yrs. 7 mos. ....da. If LESS than 1 day ....hrs. or ....min. ?

8 OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Elwood Norris.

11 BIRTHPLACE OF FATHER (State or country) St Mary Co Md

12 MAIDEN NAME OF MOTHER Helen Kirby

13 BIRTHPLACE OF MOTHER (State or country) Easton Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Helen Norris
(Address) 1906 Fleet st

15 Filed JAN 22 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 21st (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 20th 1923, to Jan 21st, 1923, that I last saw her alive on Jan 20th, 1923, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchio-Pneumonia

(Duration) ....yrs. ....mos. ....da.

Contributory Secondary —

(Duration) ....yrs. ....mos. ....da.

(Signed) E. Gordon Gall M. D.

192.. (Address) Rossville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ....yrs. ....mos. ....da. In the State, ...yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Jan 24, 19..

20 UNDERTAKER	ADDRESS
Robt J. Turner & Bro	1442 E. Broadway

If more blanks are needed, address State Registrar. 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Spec.—1-10-21—M&T—1500 Blks.

D71444 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D71444

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 656 Pitcher ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Kahn

(a) RESIDENCE NO. 656 Pitcher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of: Sigmund Kahn

6 DATE OF BIRTH (month, day, and year): Germany

7 AGE: Years 60 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Isaac Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rebecca Ault

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Isador Meyers (Address) 2905 Usman Ave.

15 JAN 22 1923 19 ROBERT R. KNABLER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/20/ 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 16, 1923, to Jan 20, 1923, that I last saw h-- alive on Jan 20, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw Grossbaus M. D.

1/4. 1923 (Address) 517 Scott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oheb Shalom Cem.

DATE OF BURIAL: 1/22/ 1923

20 UNDERTAKER: David Sondheim

ADDRESS: 118 W. Mt. Royal Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71445

CERTIFICATE OF DEATH.

101-001 D71445

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 2305 Brookfield Ave

CITY OF BALTIMORE: (No. New Edward Apts. 13 WARD)

2-FULL NAME Benjamin Manko

(a) RESIDENCE NO. New Edward Apts. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Manko.

6 DATE OF BIRTH (month, day, and year) May 22 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Automobile

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant. 645

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Raphael Manko

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Weil

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany.

14 Informant Mr. M. Lozenthal
(Address) Riviera Apts.

15 Filed JAN 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/22/1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Jan 22, 1923

that I last saw him alive on Jan 21, 1923

and that death occurred, on the date stated above, at 2.34 m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Cold

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Hospital

What test confirmed diagnosis? Physical

(Signed) R. L. Kenyon, M.D.

, 19 (Address) Westwood Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ohel Shalom Cem. DATE OF BURIAL 1/24/1923

20 UNDERTAKER David Sondheim ADDRESS 118 W. Mt. Royal Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71446

CERTIFICATE OF DEATH.

90 D71446

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2129 Mt Holly ST., 15 WARD)

2-FULL NAME Mary A. Struven

(a) RESIDENCE NO. 2129 Mt Holly ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry D. Struven

6 DATE OF BIRTH (month, day, and year): March 7, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	69	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo. F. Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Henry D. Struven 2129 Mt Holly St

15 JAN 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to Jan 20, 1923, that I last saw her alive on Jan 20, 1923, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Myocarditis -

Dilated heart

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Hypo static pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Niblett M.D.

, 19 (Address) 2220 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Jan 22 1923

20 UNDERTAKER: Wm Heckrotte Sons

ADDRESS: Mt Holly

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71447

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D71447

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2144 Division St. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Alice E. Lee

(Residence in Baltimore: No. 2144 Division St. St.; yrs. 2 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female — 4-COLOR OR RACE: colored — 5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

6-DATE OF BIRTH: Oct. 27 1922 (Month) (Day) (Year)

7-AGE: ....yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): Dependent

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Bernard Lee

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Alice Mann

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Alice Lee

(Address) 2144 Division.

15- JAN 22 1923 192.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 21, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the 2 remains described above, held an inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ....yrs. 7 mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza Pneumonia N. Contagiosa

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Jan. 22 1923 (Address) 2902 Edmondson Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Jan. 22 1923

20-UNDERTAKER: [illegible] — ADDRESS: [illegible]

U. S. Bureau of the Census. Data entered on this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71448

CERTIFICATE OF DEATH.

90 D71448

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 Marshall ST., 24 WARD)

2-FULL NAME Mary E. A. Granger

(a) RESIDENCE NO. 1313 Marshall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 1, 1904

7 AGE: Years 18 Months 5 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer: Marburg Tobacco Co.

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John W. Granger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Harriet Purdy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Mrs. Granger

(Address): 1313 Marshall St.

15 JAN 22 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 15 1923 to Jan 19 1923

that I last saw her alive on Jan 19 1923

and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

3 yrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) Wm. E. Stigler M. D.

1/20, 1923 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

DATE OF BURIAL: Jan. 22 1923

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1411 Light St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D71449

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D71449

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 565 N. Preston ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucie Young

(a) RESIDENCE NO. 565 N. Preston ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE 80 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic servic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Venetta Parks

(Address) 565 Preston ave

15 FILED JAN 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20, 23

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1923 to Jan 1923,

that I last saw h alive on Jan 17, 1923,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) John H. Tompkins M. D.

1/22/23 (Address) 1019 Saint Hilaire

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. | DATE OF BURIAL Jan 23, 23

20 UNDERTAKER Samuel Hensley | ADDRESS 1918 Bolton

N. B.—WRITE PLAINLY, WITH INK. ONE SPACE FOR EACH LETTER. THIS BLANK MUST BE FILLED OUT BY PHYSICIANS. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71450

44 D71450

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 N. Washington ST., 7 WARD)

2-FULL NAME John P. Zink

(a) RESIDENCE NO. 1018 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary L. Zink

6 DATE OF BIRTH (month, day, and year) June 21/54

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Potter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Zink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary L. Zink (Address) 1018 N. Washington

15 FILED JAN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/19 1923

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1922, to Jan 19, 1923, that I last saw h~~e~~ alive on Jan 18, 1923, and that death occurred, on the date stated above, at 7 40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) — mos. 10 ds.

CONTRIBUTORY (Secondary) General metastasis

(duration) — yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Rich M. D.

1/21/1923 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Conn. DATE OF BURIAL 1/22 1923

20 UNDERTAKER Philip Hennig ADDRESS 2016 Orleans

N. B. WHITE PAPER, WHITE CARDBOARD AND WHITE INK ONLY. PHYSICIANS should state AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71451

CERTIFICATE OF DEATH.

74-001 D71451

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4907 Hernsdale Ave. WARD 28)

2-FULL NAME Annie E Smith

(a) RESIDENCE. No. 4907 Hernsdale Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6.6	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Peter Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Geo E Smith (Address) 214 N Fulton Ave

15 Filed JAN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1923 to Jan 20 1923.

that I last saw her alive on Jan 19 1923.

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage with left side Paralysis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mrs. L. Turner, M. D.

. 19 (Address) 3501 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Jan 23 1923

20 UNDERTAKER Marlin Baker Son ADDRESS K29 W North

A. B. C. [illegible] WITH CAUTIONARY NOTICE—THIS IS A PERMANENT RECORD AND MUST BE FILLED OUT WITH UTMOST CARE. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71452

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D71452

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 Jefferson ST., 7 WARD)

2-FULL NAME William Whitaker

(a) RESIDENCE NO. 1520 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: single

6 DATE OF BIRTH (month, day, and year): Sept 23, 1892

7 AGE: Years 30 Months 3 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer): 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Paul Whitaker

11 BIRTHPLACE OF FATHER (city or town) (State or country): N Carolina

12 MAIDEN NAME OF MOTHER: Lorana Malden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant: Lee [illegible] Whitaker

(Address) 1520 Jefferson

15 JAN 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 / 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 / 1923, to Jan 20 / 1923,

that I last saw h[illegible] alive on Jan 19 / 1923,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

/ Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Richard Goodman, M. D.

Jan 22 1923 (Address) 514 Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rich Square N. C. DATE OF BURIAL: Jan 24 23

20 UNDERTAKER: R E Goode ADDRESS: 1405 McElderry

N. B. [illegible] mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D71453

CERTIFICATE OF DEATH.

D71453

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 529 N. Carey St. ST. 18 WARD)

2-FULL NAME Harry C. Bullen

(a) **RESIDENCE NO.** 529 N. Carey St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mae V. Bullen

6 DATE OF BIRTH (month, day, and year) June 10" 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Supt. Enter-

(b) General nature of industry, business, or establishment in which employed (or employer) prise Heating Co. 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Bullen

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Md.

12 MAIDEN NAME OF MOTHER Hester Demuth

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant Mrs. Harry C. Bullen

(Address) 529 N. Carey St.

15 Filed ..... 19 .....

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

22 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16" 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1922, to Jany 15, 1923.

that I last saw h[illegible] alive on Jany 15, 1923,

and that death occurred, on the date stated above, at 7.15P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
(Mitral regurgitation)
Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Indefinite.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) A. F. Arthur, M. D.

1/19 23 (Address) 1426 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL Jan 22" 1923

20 UNDERTAKER Joseph L. B. Cook ADDRESS 1003 W. Balto St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71454

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D71454

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1618 N. Gay ST., 8 WARD)

2-FULL NAME August K. Kroll

(a) RESIDENCE No. 1618 N. Gay St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 10 mos. 19 ds. How long in U. S., if of foreign birth? Dec yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 1st 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	10	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Silversmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Dionysius Kroll
11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)
12 MAIDEN NAME OF MOTHER Regina Volk
13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs. Regina Kroll
(Address) 1618 N. Gay St

15 Filed JAN 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 12 1923 to Jan 20 1923.
that I last saw h[illegible] alive on Jan 20 1923
and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Influenzae

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) B. F. Herzog M. D.
1/23, 1923 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan 23, 1923
20 UNDERTAKER	ADDRESS
Henry Horch Son	1301 E Eager

N. B.—WRITE PLAINLY, WITH PENCIL OR PEN. THE INFORMATION REQUIRED MUST BE GIVEN EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Maroney. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71455

CERTIFICATE OF DEATH.

179

D71455

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST.; 25 WARD)

2-FULL NAME Mary E. Maroney Captained. aos.

(a) RESIDENCE. NO. Mt Hope Retreat ST., 25 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 8 ds. How long in U. S., if of foreign birth? Life - yrs. mos. ds.

(If nonresident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced (or) WIFE of Mrs Maroney

6 DATE OF BIRTH (month, day, and year) Not Known.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Col	54	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo. H. Wiele

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Pa

12 MAIDEN NAME OF MOTHER Catherine Callon.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?) Ireland.

14 Informant Records Mt Hope (Address) Mt Hope Md.

15 FILED JAN 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 13th, 1923. to Jan 21, 1923, that I last saw h.. alive on Jan 21, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis.

Col (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Mania Acute

Col (duration) 0 yrs. 0 mos. 21 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan. 24 1923

20 UNDERTAKER Henry Storck Son ADDRESS 130 E Eager St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71456 HEALTH DEPARTMENT—CITY OF BALTIMORE D71456

90

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1035 Wilcox ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet E. Johnson

(a) RESIDENCE NO. 1035 Wilcox ST., 10 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis J. Johnson

6 DATE OF BIRTH (month, day, and year) 1867 Apr 12

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	9	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerville N.Y.

PARENTS

10 NAME OF FATHER J. Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

11 Informant. (Address) Mrs. Margaret Magruder 1033 Wilcox St.

12 JAN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 - 1923

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922, to Jan. 19, 1923, that I last saw her alive on " 19, 1923, and that death occurred, on the date stated above, at 5:20 a. m.

The CAUSE OF DEATH* was as follows:

Mitral heart disease.

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Edwin B. Fenby, M. D.

1/19/1923 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Jan. 22 1923
20 UNDERTAKER	ADDRESS
H. C. Wedefeld	914 Gunner St.

Spec.—1-10-23—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D71457

D71457

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2639 Hampden ave WARD 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Conolon

(a) RESIDENCE NO. 3250 Cedar ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	✓ ✓

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓ ✓

6 DATE OF BIRTH (month, day, and year) Jan 4 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	✓	✓	3/4 hr.	3/4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) M.D
(State or country)

PARENTS

10 NAME OF FATHER John F Conolon

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Maggie Houston

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant John F Conolon
(Address) 3250 Cedar ave

15 Filed JAN 5 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923, to Jan 4, 1923.

that I last saw h[illegible] alive on Jan 4, 1923,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth 5½ mo.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1/5. 1923 (Address) 2020 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — DATE OF BURIAL Jan 5 1923

20 UNDERTAKER Chenoweth Son — ADDRESS Chestnut Ave

N.B. Physicians are requested to fill out this certificate with the greatest care. Every question should be answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D71458

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D71458

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas P. Johnson

(a) RESIDENCE NO. 922 Pennsylvania ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Chas. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) [illegible]

15 Filed JAN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1922, to Jan. 17, 1923,

that I last saw him alive on Jan. 17, 1923,

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax

(duration) yrs. 2 mos. 17 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Padgliacci M. D.

1-17-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS JAN 22 1923

Please write plainly, carefully supplied. AGE should be carefully supplied. PHYSICIANS should state mation should be carefully in plain terms, so that it may be CAUSE OF DEATH in plain terms. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

21

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71459 9 D71459

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 W. Cross ST.: 21 WARD)

2-FULL NAME Thelma Barney

(a) RESIDENCE. NO. 509 W Cross ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Barney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Foote

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

11 Informant James Barney (Address) 509 W Cross St

15 [illegible]

JAN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/20/1923

17 I HEREBY CERTIFY, That I attended deceased from 1/18/1923 to 1/20/1923 that I last saw h[illegible] alive on 1/20/1923 and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (duration) about 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Pertussis (duration) about 2 yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Guy Bowley M. D.

1/22/1923 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Jan 23 1923

20 UNDERTAKER J. W. Bloom's Son ADDRESS Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D71460

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D71460

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2870 O'Donnell St. ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kunigunda Kissner.

(a) RESIDENCE NO. 2870 O'Donnell. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Kissner

6 DATE OF BIRTH (month, day, and year) Feb. 28 - 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Bertsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Neubauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) George Kissner 2870 O'Donnell St.

15 FILED JAN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 19, 1923, that I last saw him alive on Jan 17, 1923, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Thomas B Fitlow M. D.

1/21, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem

DATE OF BURIAL Jan 23 1923

20 UNDERTAKER Lilly and Zeiler

ADDRESS 403 S Wolfe St

N. B.—WRITE PLAINLY, WITH INK AND IN LANGUAGE UNDERSTOOD BY THE PEOPLE. ALL QUESTIONS SHOULD BE ANSWERED EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71461

CERTIFICATE OF DEATH.

91-002 D71461

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3407 Piedmont ST., 15 WARD)

2-FULL NAME Carolina Margaret Crass

(a) RESIDENCE NO. 3407 Piedmont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~
~~HUSBAND of~~ (or) WIFE of Henry Weiban Crass

6 DATE OF BIRTH (month, day, and year) ~~Jan 22 23~~ Sep. 19-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	71	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carl Musch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER M. Weil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. C. M. Crass

(Address) 3407 Piedmont

15 Filed JAN 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 1923 to Jan 22 1923

that I last saw h~~e~~r alive on Jan 22 1923

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis

Myocarditis - (20 days)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute dilatation - 2 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) U. S. Tibbatts, M. D.

1/22, 1923 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews Cem. DATE OF BURIAL Jan 25 '23

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE AND RECORD, EACH item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D71462

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 105 Woodlawn Road ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh S. Orem

(a) RESIDENCE. NO. 105 Woodlawn Road ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ida M. Orem

6 DATE OF BIRTH (month, day, and year) Nov 14 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Canned Goods Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Perry C. Orem

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co, Md.

12 MAIDEN NAME OF MOTHER Catherine Shuler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Ida M. Orem (Address) 105 Woodlawn Road

15 JAN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan-14. 1923. to Jan. 21. 1923.

that I last saw him alive on Jan. 21. 1923.

and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

La Grippe & Confluent Bronchial Pneumonia

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. F. Foltz M. D.

1/21, 1923 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL January 23 1923

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71463

CERTIFICATE OF DEATH.

5 101-001 ✓

D71463

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 428 N. Central ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Travers

(Residence in Baltimore: No. 428 N. Central St St.; 20 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec. 8 1895 (Month) (Day) (Year)

7-AGE, 27 yrs. ..... mos. 1 ds. 25 If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... House work
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), St. Mary's.

PARENTS.

10-NAME OF FATHER, Benjamin Tippet.

11-BIRTHPLACE OF FATHER (State or Country), St. Mary's

12-MAIDEN NAME OF MOTHER Annie Tucker.

13-BIRTHPLACE OF MOTHER (State or Country), St. Mary's

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cecelia Cornish

(Address) 1407 Orleans st.

15-

Filed JAN 22 1923. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 21 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1923, to Jan 21 1923, that I saw her alive on Jan 21 1923, and that death occurred, on the date stated above, at 5:20 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) Pyelitis

(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) R. J. Lyons M. D.

1/22, 1923 (Address) 1429 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery. DATE OF BURIAL, Jan. 25, 1923.

20-UNDERTAKER Mrs. J. E. Locke. ADDRESS 1302 Jefferson St.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71464

CERTIFICATE OF DEATH.

31 D71464

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 N. Stricker ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethel Downing

(Residence in Baltimore: No. 911 N. Stricker St St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec. 10, 1906?, 1 (Month) (Day) (Year)

7-AGE, 17 yrs. ..... mos. 1 ds. 13

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, John Downing

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mollie Wright

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mollie Wright

(Address) 911 Stricker st

15-

Filed JAN 22 1923 H. J. R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 19, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 16 1922, to Jan 19 1923, that I saw h[illegible] alive on Jan 18 1923, and that death occurred, on the date stated above, at 6 15 P.m.

The CAUSE OF DEATH* was as follows:

Pulm. T.B. C

(Duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) R J Downing M. D.

1/22, 1923 (Address) 1429 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel County. DATE OF BURIAL, Jan 23, 1923

20-UNDERTAKER Mrs. J. G. Locke. ADDRESS 1302 Jefferson St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D71465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D71465

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 E. Monument ST., 5 10 WARD)

2-FULL NAME Richard Brown.

(a) RESIDENCE NO. 1012 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~: Mary Brown

6 DATE OF BIRTH (month, day, and year): Oct, 18, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Trimmer

(b) General nature of industry, business, or establishment in which employed (or employer): Business

(c) Name of employer: (Own)

9 BIRTHPLACE (city or town) (State or country): Frederick, Maryland.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Adeline —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Mary Brown

(Address) 1012 E. Monument St.

15 JAN 22 1923 Filed ....., 19 .....

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan, 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec, 2, 1922, to Jan, 21, 1923, that I last saw h[illegible] alive on Jan, 20, 1923, and that death occurred, on the date stated above, at 4.05 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Spasmodic Bronchitis, Emphysema, & Chronic Myocarditis.

(duration) 2 yrs.? — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Wm Franklin M. D.

1/21, 1923 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: 24 Jan 1923

20 UNDERTAKER: Wm. J. G. Locke.

ADDRESS: 1302 Jefferson

Spec.—1-10-21—M&T—1500 Bks.

D71466

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1923 D71466

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.,) 3201 Greenmount ave ST., 9 WARD)

2-FULL NAME Ricka Leinig — Geyer

(a) RESIDENCE NO. 3201 Greenmount Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Wm M. Geyer

6 DATE OF BIRTH (month, day, and year) January 1st 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Zanzow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Muth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs A Snyder (Address) Altoona ave Hamilton

15 JAN 22 1923 ROBERT R. KRAUTER, Registrar
Burial ~~Permit~~ Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1923, to Jan. 21, 1923, that I last saw her alive on Jan 21, 1923, and that death occurred, on the date stated above, at 4.48 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
Pulmonary Oedema.

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Asthma - Chronic Nephritis. (duration) about 6 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs - Laboratory

(Signed) J. J. Robb, M. D.

, 19 (Address) 1300 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 24th 28
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71467

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D71467

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5324 Florence Ave (WARD) 24

2-FULL NAME George Rousseau

(a) RESIDENCE NO. 5224 Florence ST. Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced (or) ~~WIFE~~ of Susan Rousseau

6 DATE OF BIRTH (month, day, and year) ~~Sept~~ Oct 22-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

(c) Name of employer H. A. Long

9 BIRTHPLACE (city or town) (State or country) Bristol Pa ~~Trenton N.J.~~

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Trenton N J

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Trenton N J

14 Informant Susan Rousseau
(Address) 5224 Florence Ave

15 Filed JAN 22 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1923, to Jan 23, 1923, that I last saw him alive on Jan 23, 1923, and that death occurred, on the date stated above, at 9:45 P m.

The CAUSE OF DEATH* was as follows:

Paralysis -
due to a rupture of blood vessels in the brain -
(duration) 3 days ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) G. H. Buckley M. D.

, 19 (Address) 126 W Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trenton N J. — DATE OF BURIAL 1/25 1923

20 UNDERTAKER W P Cook Co — ADDRESS 502 E North

JAN 22 1923

3.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71468

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 D71468

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 333 E 20th ST., (WARD) 12

2-FULL NAME William J Fowler

(a) RESIDENCE NO. 333 E 20th ST., 12 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florida J. Fowler

6 DATE OF BIRTH (month, day, and year) Jan 4, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Hillery Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John B Egerton (Address) 333 E 26th St

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Jan 21, 1923

that I last saw h[illegible] alive on Jan 19, 1923

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald D Tonry M. D.

, 19 (Address) 414 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Jan 23 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

2215 23

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71469 D71469

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 910 Harlem Av ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa D Robert

(Residence in Baltimore: No. 910 Harlem Av St.; 15 yrs., mos. ds.)

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 28, 1853 (Month) (Day) (Year)

7-AGE, 69 yrs. 9 mos. 25 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Richmeier

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Fredericka Markert

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora Igleheart

(Address) 910 Harlem Ave

15- Robert P. Harrison, Jan 22 1923, 191

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 22, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 191 5, to Date 1923, that I saw h alive on Jan 21 1923, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Bright Disease

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 8 yrs. mos. ds.

(Signed) C. S. Trunz M. D.

Jan 24 1923, 191 (Address) 841 W Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem DATE OF BURIAL, Jan 24 1923

20-UNDERTAKER Harry J Armacost ADDRESS 1702 Ridgewood Ave

Spec.—1-10-21—M&T—1500 Bks.

D71470

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71470

CERTIFICATE OF DEATH.

118-102

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1.-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 16 WARD)

2.-FULL NAME Lena Miller

(a) RESIDENCE NO. 2918 Edmondson Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7 1858.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Max Hillmeyer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Agatha Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. C. Becker
(Address) 2918 Edmondson Ave.

15 JN 22 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/21 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/20, 1923, to 1/21, 1923,

that I last saw her alive on 1/21, 1923,

and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Umbilical hernia.
(strangulated)

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Acute intestinal obstruction.

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes. Date of 1/20/23.

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) J. Willis Brayton, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 1/23 1923

20 UNDERTAKER Wm. M. Gawthrop

ADDRESS 2839 Rayner

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

7 1471

CERTIFICATE OF DEATH.

11-001 D71471

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Lyndhurst ST., 16 WARD)

2-FULL NAME Stephen Penniman Heath

(a) RESIDENCE NO. 604 Lyndhurst ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced, (write the word)~~
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ann M. Heath

6 DATE OF BIRTH (month, day, and year) April 3rd, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist (Retired) 31

(b) General nature of industry, business, or establishment in which employed (or employer) Machine Gun Dep't U. S. Navy Yards.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Savage Md.

PARENTS

10 NAME OF FATHER Stephen P. Heath.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Mrs Ann M. Heath 604 Lyndhurst St.

15 Robert P. Harrison, 19 ..... Registrar

Burial Permit Clerk.

JAN 22 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21st, 19 23

17 I HEREBY CERTIFY, That I attended deceased from Jan 18 1923 to Jan 21 1923

that I last saw h.. alive on Jan 21 1923

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Homer C. Wood, M. D.

1/22 1923 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Jan 23 19 23

20 UNDERTAKER: Bertram Wyse

ADDRESS 1923 W Lafayette Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16997
D71472

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71472

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME Carl Jones

(a) RESIDENCE NO. 1125 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 15-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Harry Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mildred Lyons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Robert F. Harrison, Burial Permit Clerk. Registrar

JAN 22 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15th, 1923, to Jan 21st 1923, that I last saw him alive on Jan 21st, 1923, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Ulcerative stomatitis (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Jan. 23 1923

20 UNDERTAKER Edward Smyth — ADDRESS 1463 N Carey

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71473

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71473

CERTIFICATE OF DEATH. 100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1176 Nanticoke St.: 21 WARD)

2-FULL NAME Leona Graves

(a) RESIDENCE. No. 1176 Nanticoke St., WARD.....

(Usunl place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 8-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Wm. T. Graves

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Leona Mac

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs T. Graves
(Address) 1176 Nanticoke St

15 Filed , 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

JAN 22 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923, to Jan 21, 1923, that I last saw her alive on Jan 20 1923, and that death occurred, on the date stated above, at 2.10 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J M Dilnett M. D.

Jan 22, 1923 (Address) 621 Washington Boulevard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additionnl space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Jan 23 19 22
20 UNDERTAKER John Fields	ADDRESS 1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... uld state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement ... OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71474

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71474

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 24 WARD)

2-FULL NAME Gertrude Gilka

(a) RESIDENCE. No. Franklin & Orchard Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10th 1889

7 AGE 33 Years | Months 10 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Gilka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Koschutzke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Koschutzke (Address) Franklin & Orchard Ave.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

4 22 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1923, to Jan. 21, 1923, that I last saw h.er alive on Jan 21, 1923, and that death occurred, on the date stated above, at 4.05 P m.

The CAUSE OF DEATH* was as follows:

acute myocardial insufficiency.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Enteritis (appendic)

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Frank C. Harris, M. D.

1/24, 1923 (Address) 1300 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Most Holy Redeemer Cem.

DATE OF BURIAL: Jan 24th 1923

20 UNDERTAKER: Wilbur W. Shriver

ADDRESS 118 Edmondson Ave.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71475 D71475

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 Rose St., 6 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alenda J Chesney

(a) RESIDENCE NO. 222 Rose St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Chesney deceased

6 DATE OF BIRTH (month, day, and year) Mar 10-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Elias Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. R. Chesney

(Address) 136 Edmondson Ave

15 Jan 22 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/20 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Jan 20, 1923.

That I last saw her alive on Jan 20, 1923.

and that death occurred, on the date stated above, at 4 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Interstit Nephritis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. A. Meyer M. D.

1/20, 1923 (Address) N. 38 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL Jan 23 1923

20 UNDERTAKER Wm C. Miller

ADDRESS 2334 Jefferson St

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D71476

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D71476

REGISTERED NO.

1-PLACE OF DEATH Boyview Hospital

CITY OF BALTIMORE: (No. 26 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wright

(a) RESIDENCE NO. Boyview Insane Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	34(?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER Charles Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Hospital Records

15 JAN 22 1923, 19 Robert P. Harrison, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/20/23 19

17 I HEREBY CERTIFY, That I attended deceased from 1/15/23, 19, to 1/20/23, 19, that I last saw him alive on 1/20/20, 19, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Gaining to Heart Failure

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Insensibility from birth

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J A Mecko M. D.

, 19 (Address) Boyview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn City — DATE OF BURIAL Jan 23 1923

20 UNDERTAKER George H Holland — ADDRESS 163 Conrad Hilton

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71477

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71477

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ray Jackson

(a) RESIDENCE NO. 1504 Guilford Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? 1 yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Oct 28, 1921

7 AGE: 1 Years 2 Months 22 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): Iron Child

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Robt Toney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Annie Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Haywood Scott

(Address): 1610 Eutaw Pl

15 JAN 22 1923, 19

Robert F. Morrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-21-1923

17

I HEREBY CERTIFY, That I attended deceased from 1-17-, 1923, to 1-21-, 1923,

that I last saw him alive on 1-21-, 1923,

and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Bilateral Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1/21 1923 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Cemetery

DATE OF BURIAL: Jan 25 1923

20 UNDERTAKER: George H. Holland

ADDRESS: 1631 Lorraine Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71478 ✓ D71478

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 Laurens ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses K. Amby

(a) RESIDENCE. NO. 509 Laurens ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 11 mos. 12 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN shou CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Betty Amby

6 DATE OF BIRTH (month, day, and year) Jan. 31-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	22	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laboring work.

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer for himself.

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs. Betty Amby
(Address) 509 Laurens St

15 Filed JAN 22 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22-1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19 21, to Jan 22 1923, that I last saw him alive on Jan 19 1922, and that death occurred, on the date stated above, at 1.45 a m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(duration) 1 yrs. 2 mos. X ds.

CONTRIBUTORY (Secondary) Bright's Disease and uremia

(duration) X yrs. X mos. 7 ds.

18 Where was disease contracted if not at place of death? not known.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Chemical & clinical

(Signed) P. B. Wilson, M. D.

, 19 (Address) 1124 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Jan 24 192
20 UNDERTAKER George E. A. Gilson	ADDRESS 513 Laurens St

D71479

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71479

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Mary Wesley

(Residence in Baltimore: No. 2020 Bond St 37 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-Single, Married, Widowed or Divorced, (Write the word.) Widowed

6-DATE OF BIRTH. ..... 1..... (Month) (Day) (Year)

7-AGE. 37 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 070

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. John H. Wilson

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Ellen Gulden

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elijah Wesley Trustmt.

(Address) 2020 Bond St

15- Robert F. Harrison,

..... 192.....

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 23 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis - Toxemia

(over)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) 2nd & 3rd degree burns

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) J. H. Wallace M. D.
(Coroner.)

1-22 1923 (Address) 518 E Monument

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Mt. Auburn Cemy Jan 24 1923

20-UNDERTAKER. ADDRESS
George H. Holland 1631 Druid Hill Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D22132

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ~ D71480

1-PLACE OF DEATH D71480 Registered No. C.....

City of BALTIMORE: (No. #2521-Madison-Av. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME FERNANDO VOLKMAR

Residence in Baltimore: No. #2521-Madison-Av. (13-Ward) St.; 65 yrs., 3 mos., 12 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. October (Month) 8 (Day) 1857 (Year)

7-AGE. 65 yrs. 3 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Member of firm of G. T. Sadtler-Sons
(b) General nature of industry, business, or establishment in which employed (or employer): Jewelers-Opticians.

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. George D. Volkmar.

11-BIRTHPLACE OF FATHER, (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Louisa Sommerlock

13-BIRTHPLACE OF MOTHER, (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. A. Volkmar, (brother)

(Address) 2521-Madison-Av., City.

15- FILED JAN 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 21 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to ... death on the date stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema
Heart

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) John Thorenson M. D.
(Coroner.)

Jan 21 1923 (Address) 749 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
DRUID RIDGE CEMETERY.	JAN-23-23. 19

20-UNDERTAKER.	ADDRESS
STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	108 W. NORTH AVE.

Spec.—1-10-21 M&T 1500 Bks.

D71481

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D71481

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3031 Walbrook Ave ST., 15 WARD)

2-FULL NAME Clara A. Watkins

(a) RESIDENCE NO. 3031 Walbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Watkins

6 DATE OF BIRTH (month, day, and year) June 20-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md.

PARENTS

10 NAME OF FATHER John Quick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Husband

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Watkins

(Address) 3031 Walbrook av.

15 JAN 23 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1922, to Jan 22, 1923, that I last saw h-- alive on Jan 21, 1923, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Tudor Wheeler M. D.

1/23 193 (Address) 212 Glenmore Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fork Balto Co. Md

DATE OF BURIAL Jany 24 1923

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1944 W. Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71482

CERTIFICATE OF DEATH.

197

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. Franklin Square Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James Hopkins

(Residence in Baltimore: No. 726 N Arlington ave St.: yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, ..., 1878
(Month) (Day) (Year)

7-AGE, 37 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Hd

9-BIRTHPLACE, (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, ... Hopkins

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER ..... Unknown

13-BIRTHPLACE OF MOTHER (State or Country), S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carry Halladay

(Address) 726 N. Carlington ave

15-

FILED JAN 23 1923 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan 17, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound in Brain Homicide

..... (Duration) ..... yrs. ..... mos. 2 hrs.

CONTRIBUTORY (Secondary) Hemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Preston M. D.
(Coroner.)

Jan 18, 1923 (Address) 750 E. Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

503 N. Mount St.

Former or usual residence 726 N. Arlington ave

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem — DATE OF BURIAL, 1-23-, 1923

20-UNDERTAKER Wm E Taylor — ADDRESS 916 Pa ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. Do not fold this certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71483

D71483

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 McCulloh ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Hayden

(Residence in Baltimore: No. 2120 McCulloh St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 1894, 1 (Month) (Day) (Year)

7-AGE, 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert W. Lutes

(Address) 1836 Druid Hill Ave

15-

Filed ..... 191.....

JAN 23 1923

ROBERT B. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 21st, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 14th 1923 to Jan 21st 1923.

that I saw h[illegible] alive on Jan 21st 1923

and that death occurred, on the date stated above, at 6:20 p.m.

The CAUSE OF DEATH* was as follows:

Pul Tuberculosis

6 mos. 6 ds. (Duration)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. Ree Ellis M. D.

1/23/1923 (Address) 924 Mount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, McCulloh

DATE OF BURIAL, Jan 23rd, 1923

20-UNDERTAKER Laurence E. Wright

ADDRESS 1264 Mary

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71484

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71484

31

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL
" " "
CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

2-FULL NAME Tella Thomas

(a) RESIDENCE NO. 2017 Mc Culloch St. City WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~WIFE~~ of Cora (Cousin).

6 DATE OF BIRTH (month, day, and year) June, 17th - ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	31.	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H. W.
(b) General nature of industry, business, or establishment in which employed (or employer) (")
(c) Name of employer (")

9 BIRTHPLACE (city or town) (") (State or country) Maryland.

PARENTS
10 NAME OF FATHER Tora Bailey
11 BIRTHPLACE OF FATHER (city or town) (") (State or country) Maryland
12 MAIDEN NAME OF MOTHER Sarah Lasson.
13 BIRTHPLACE OF MOTHER (city or town) (") (State or country) Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL. Records.

15 JAN 23 1923 19 JOSEPH R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan, 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1923, to Jan 21, 1923, that I last saw her alive on Jan 21, 1923, and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:
Miliary Tuberculosis

(duration) yrs. 3/ mos ..... ds.

CONTRIBUTORY (Secondary) (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? ..... What test confirmed diagnosis? .....

(Signed) Chas R Bagg M. D.
19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Denton Md — DATE OF BURIAL Jan 23rd 1923

20 UNDERTAKER Hammond Wright — ADDRESS 364 McCaryll

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Luby.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D71485

CERTIFICATE OF DEATH.

101-001 D71485

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 424 E. 21st St. ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daml J. Luby

(a) RESIDENCE. No. 424 E 21st. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Luby

6 DATE OF BIRTH (month, day, and year) Sept 14-1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R.R. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 613

(c) Name of employer Penna. R.R.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John J. Luby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Marg. Madigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret Luby

(Address) 424 E. 21st

15 Filed JAN 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22. 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Jan. 22, 1923, that I last saw him alive on Jan 22, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Tobacco amblyopia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

1-22 1923 Address) 120 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 1/25 23

20 UNDERTAKER Wm Cook — ADDRESS 502 E Vol

Spec. 6-9-19—H. P. Co.—1000 Bks.

D71486 HEALTH DEPARTMENT—CITY OF BALTIMORE D71486

CERTIFICATE OF DEATH. X 10

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

2-FULL NAME Airs Pauline Wolff

(a) RESIDENCE. NO. 1100 N. Fulton ave ST. WARD. Frederick, Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept 29-1913

7 AGE: Years 9 Months 3 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Frederick, Md

PARENTS

10 NAME OF FATHER: Ed Wolff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER: May Barthalow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Md

14 Informant: Edward E. Wolfe

(Address): 1100 N. Fulton ave

15 JAN 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1923, to Jan 21, 1923, that I last saw h[illegible] alive on Jan 21, 1923, and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Tracheotomy Date of 1/21/23

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Ella Gowan, M. D.

1/22/23 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Frederick Md

DATE OF BURIAL: 1/23 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71487

CERTIFICATE OF DEATH.

90 D71487

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1554 N Wolf ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Abbie Warmbrod Sa.

(a) RESIDENCE NO. 612 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Heizman

6 DATE OF BIRTH (month, day, and year) Sept. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar maker

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar Mfr

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant George Warmbrod (Address) 3204 E Fayette

15 FILED JAN 23 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1923, to Jan. 21, 1923.

that I last saw h— alive on Jan 21, 1923.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 612 E Eager

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Thomas M Hawkins, M. D.

1-24-23 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt. Covenant — DATE OF BURIAL Jan 24 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71488

CERTIFICATE OF DEATH.

49 D71488

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1932 Patterson Place WARD 8)

2-FULL NAME Charles H Blades

(a) RESIDENCE NO. 1932 Patterson Place ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Louisa Blades

6 DATE OF BIRTH (month, day, and year): Aug 18 1855

7 AGE — Years: 67 — Months: 5 — Days: — If LESS than 1 day, ...hrs. or.....min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): Bakery

(c) Name of employer: Retail

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel Blades

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbot Co

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Talbot Co

14 Informant (Address): Louisa Blades 1932 Patterson Place

15 Filed JAN 23 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 10 - 1922 to Jan 21 1923.

that I last saw him alive on Jan 21 1923, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Exhaustion 2 days

CONTRIBUTORY (Secondary) Osteo Sarcoma of Lower Jaw (duration) 5 yrs. 6 mos. 12 ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Course

(Signed) Louis Wolf M. D.

. 19 (Address) 1001 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — DATE OF BURIAL: Jan 24 1923

UNDERTAKER: William Cook — ADDRESS: 502 E Madison St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71489 74-001 D71489

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1614 Rutland ave

CITY OF BALTIMORE: (No. 1614 Rutland ave ST. 8 WARD)

2-FULL NAME William Jackson Neilson

(a) RESIDENCE No. 1614 Rutland ave ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~ or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth Neilson

6 DATE OF BIRTH (month, day, and year) April 22 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Typesetter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Neilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hepperd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Wife Elizabeth Neilson (Address) 1614 Rutland ave

15 JAN 23 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1923, to Jan. 20, 1923, that I last saw him alive on Jan. 20, 1923, and that death occurred, on the date stated above, at 4.20 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual clinical tests

(Signed) C. H. Broadmead, M. D.

Jan 21, 1923 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	Jan 23 1923

20 UNDERTAKER Robt. J. Turner Jr. ADDRESS 1412 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71490

CERTIFICATE OF DEATH.

90 D71490

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 S Paca ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm McConnelly

(Residence in Baltimore: No. 1009 S Paca St.; ....yrs....mos....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 5, 1905 (Month) (Day) (Year)

7-AGE, 17 yrs. 4 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)..... Do

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm E Connelly

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Mary Wachsmuth

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Connelly

(Address) 1009 S Paca

15- FILED JAN 23 1923 191.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 21, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1922, to Jan 21 1923, that I saw h— alive on Jan 21 1923, and that death occurred, on the date stated above, at 5.25 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(Duration) ...yrs....mos. 1 day

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ...yrs. 6 mos....ds.

(Signed) John G Schwarm M. D.

1-24-23, 191.. (Address) 117 W Lexington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem DATE OF BURIAL, Jan 24, 1923

20-UNDERTAKER, Robt J Turner & Son ADDRESS 1442 N Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71491

CERTIFICATE OF DEATH.

X 1-001 D71491

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME Axel Nicholson

(a) RESIDENCE NO. 2 S. Anna ST., ... WARD .....
(Usual place of abode) Norwegian U. Con'
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1894

7 AGE — Years: 28 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor. 886

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Sweden.

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): Norwegian Lutheran Church

15 Filed JAN 23 1923 ROBERT A. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1923, to Jan. 21, 1923, that I last saw h[illegible] alive on Jan 20, 1923 and that death occurred, on the date stated above, at 12 45 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

Broncho Pneumonia

(duration) yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary): Cardiac Failure

(duration) yrs. ..... mos. ..... 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) ..... M. D.

, 19 (Address) Owings Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: Jan 23, 23

20 UNDERTAKER: Robt J. Johnston

ADDRESS: 1 N Gay

Spec.—1-10-21—M&T—1500 Bks.

D71492

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

D71492

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Madison Ave & Bloom Sts

CITY OF BALTIMORE: (No. Bellevue-Manchester St. 424 WARD)

2-FULL NAME Selma W. Johnson

(a) RESIDENCE NO. Bellevue-Manchester Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Robinson

6 DATE OF BIRTH (month, day, and year): Aug 27 1848

7 AGE: Years 74 | Months 4 | Days 25 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bristol England

PARENTS

10 NAME OF FATHER: Lazarus Glanz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Bloman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Jonas Robinson

(Address) 3526 Reisterstown Road

15 JAN 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1922 to Jan 21, 1923,

that I last saw h alive on Jan 21, 1923,

and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos 5 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo W Emmerton M. D.

1-22, 1923 (Address) 3002 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bolts Hebrew Cemetery — DATE OF BURIAL: Jan 24 1923

20 UNDERTAKER: J. Ahrens & Co. — ADDRESS: 1611 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D71493

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D71493

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 S. Stricker St. ST., 19 WARD)

2-FULL NAME Ida Helen Weber

(a) **RESIDENCE** No. 234 S. Stricker St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin F. Weber

6 DATE OF BIRTH (month, day, and year) July 6" 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
55	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Schulze

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Europe

12 MAIDEN NAME OF MOTHER Helena Thrin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Europe

14 Informant Benjamin Weber

(Address) 234 S. Stricker St.

15 Filed JAN 23 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21" 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to Jan 21, 1923,

that I last saw h-e alive on Jan 20, 1923,

and that death occurred, on the date stated above, at 12.43A. m.

The CAUSE OF DEATH* was as follows:

Cancer

Pernicious Anemia

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cancer of Liver

(duration) 5 yrs. - mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) John A Evans M. D.

1/22 19 23 (Address) 101 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Jan 23, 1923

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 W. Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71494

D71494

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

1-PLACE OF DEATH 611 Wyeth St.

CITY OF BALTIMORE: (No.) (St.: 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Meyers.

(a) RESIDENCE. NO. 611 Wyeth St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. — mos. — ds. How long in U. S., if of foreign birth? 69 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Meyer

6 DATE OF BIRTH (month, day, and year) April 21 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germy

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Mamie Sackhoff

(Address) 611 Wyeth St

15 Filed JAN 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1923, to Jan. 21, 1923, that I last saw h~~er~~ alive on Jan. 21, 1923, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Booth, M. D.

, 19 (Address) 602 Washington Blvd.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 24 1923
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	2173 Pico

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71495

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71495

11-001

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 323 S. Bond St.; 3 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Edna P. Harris

(a) RESIDENCE. No. 323 S. Bond St., ... Ward. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ford Harris

6 DATE OF BIRTH (month, day, and year): July 1890

7 AGE: Years 32 [redacted] Months 6 Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF [redacted]LEASED

(a) Trade, profession or particular kind of work: Hsw.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Westport Va. Va

PARENTS

10 NAME OF FATHER: Edward Purcell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Edna Purcell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs. Harris

(Address) 323 S. Bond St.

15 FILED JAN 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1923, to Jan 21, 1923, that I last saw h[redacted] alive on Jan. 21, 1923, and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Influenza [redacted] Broncho-Pneumonia

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Noel J. Fearing M. D.

1/21, 1923 (Address) 2052 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westport Va.

DATE OF BURIAL: January 23 1923

20 UNDERTAKER: Wendell Diffel & Son

ADDRESS: 378 Am

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

166-001 D71496

D71496

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 271 Canal St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Smith

(Residence in Baltimore: No. 271 Canal St.; 11 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. THIS IS PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Color

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct. 29th, 1922 (Month) (Day) (Year)

7-AGE, 0 yrs. 2 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~
(b) General nature of industry, business, or establishment in which employed (or employer) ~

9-BIRTHPLACE, (State or Country), 271 Canal St Balto Md

PARENTS.

10-NAME OF FATHER, Walter Johnson

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Edna Smith

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Smith

(Address) 271 Canal St

15-Filed JAN 23 1923 191..... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 22nd, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 17th 1923, to Jan 22nd 1923, that I saw h[illegible] alive on Jan 19th 1923, and that death occurred, on the date stated above at 6:20 P.M.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Lee Ellis M. D.

1/23 1923 (Address) 814 N Mad

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Jan. 23 1923

20-UNDERTAKER Samuel Hensley ADDRESS 578 N Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001

D71497 REGISTERED NO. D71497

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 Division St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josefatine Smith

(Residence in Baltimore: No. 1724 Division St.; 35 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) 1879 (Day) 1 (Year)

7-AGE, 44 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer)..... Private

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, William Jennings

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rebecca Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs. Rosa Ford

(Address)..... 1724 Division St.

15-

Filed JAN 23 1923 ..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Jan. (Day) 20 (Year) 1923

17- I HEREBY CERTIFY, That I attended deceased from Jan. 4 1923, to Jan 20 1923, that I saw h— alive on Jan 20 1923, and that death occurred, on the date stated above, at 1.05 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Tuberculosis Intestines

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) A. Lee Allen M. D.

1923, 192.. (Address) 924 Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Jan 25, 1923

20-UNDERTAKER Samuel Hensley ADDRESS 878 Eddison St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D71498 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71498

CERTIFICATE OF DEATH.

111-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Bunting

(a) RESIDENCE. NO. 617 E. 30th. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara L. Wright

6 DATE OF BIRTH (month, day, and year) Dec. 25 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer W. R. & E. Co.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Charles S. Bunting

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Do not know

13 HIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Clara L. Bunting

(Address) 719 E. 34th St

15 JAN 23 1923 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to Jan. 21, 1923, that I last saw h. in alive on Jan. 21, 1923, and that death occurred, on the date stated above, at 7 20 a m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis Ulcer.

(duration) about 2 years yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of Jan. 16'23

Was there an autopsy? No.

What test confirmed diagnosis? T. S. S.

(Signed) Harold C. Pilsbury, M. D.

, 19 (Address) St Joseph Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 1/23 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert St.

Spec.—1-10-21—M&T—1500 Bks.

Hartley

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71499

CERTIFICATE OF DEATH.

101-001 D71499

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen'l Hospital ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Sarah E Hartley

(a) RESIDENCE NO. 324 Hawthorne Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Hartley

6 DATE OF BIRTH (month, day, and year) Feb. 16, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Morgan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Lester

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs Ella McGinley
(Address) 324 Hawthorn Road

15 JAN 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/26/23

17 I HEREBY CERTIFY, That I attended deceased from 1/10/23, 19..... to 1/26/23, 19.....

that I last saw her alive on 1/20/23, 19.....

and that death occurred, on the date stated above, at 5-18 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical findings

(Signed) J. A. Tompkins, M. D.

, 19 (Address) Md Gen'l Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 1/23 1923

20 UNDERTAKER Henry W. Means & Son — ADDRESS 805 N. Calvert St.

Spec.—8-24-14—M. & T.—2000 Bks.

Bernie Selko

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71500

CERTIFICATE OF DEATH.

71-001

D71500

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 858 W. Balto St ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernie Selko

(Residence in Baltimore: No. 858 W. Balto St St.; 2 yrs., 2 mos. — ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. Nov (Month), — (Day), 1920. (Year)

7-AGE. 2 yrs. 2 mos. — ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Louis Selko

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Rosa Levin

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. Selko

(Address) 858 W. Balto St

15-

Filed JAN 23 1923, 191.... ROBERT B. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. January (Month) 22nd (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 6th 1923, to Jan 22nd 1923, that I saw h[illegible] alive on Jan 22nd 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Streptococcus meningitis

(Duration) — yrs. — mos. 21 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. R. Fraser M. D.

Jan 22, 1923 (Address) 614 N. Carrollton Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Woodlawn Rosedale

DATE OF BURIAL. 1-23-, 1923.

20-UNDERTAKER S. Levinson

ADDRESS 1127 E. Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

Susan A. Nichols

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71501 ✓ D71501

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2554 W. Balto St. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan A. Nichols

(a) RESIDENCE. No. 2554 W. Balto ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Feb 13/1850

6 DATE OF BIRTH (month, day, and year) Feb 13, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph D. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Abigail Sands

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant (Address) Mary A. Faithhall 2522 W. Balto

15 Filed JAN 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 22 1923.

17 I HEREBY CERTIFY, That I attended deceased from August, 19 19, to Jan 22, 1923, that I last saw her alive on Jan 21, 1923, and that death occurred, on the date stated above, at 2:45 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Insip -

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Urinary -

(Signed) Stanley Reynolds, M. D.

Jan 23, 1923 (Address) 11 W. Conway St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 22 23

20 UNDERTAKER Jasiuka Dyer ADDRESS 1600 N. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71502

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D71502

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 N Bruce ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Smith

(a) RESIDENCE. No. 312 N Bruce ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colrd | 5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Addison Smith

6 DATE OF BIRTH (month, day, and year) Dec 15 1857

7 AGE: Years 66 | Months 1 | Days 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer: Self- Home work

9 BIRTHPLACE (city or town) (State or country): Essex Co Va

PARENTS
10 NAME OF FATHER: Moses Johnson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Essex Co Va
12 MAIDEN NAME OF MOTHER: Not known
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Fanny L Fisher
(Address): 312 N Bruce

15 FILED JAN 23 1923 ROBERT R. KRAUTER (Registrar) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1923, to Jan 20, 1923, that I last saw h alive on Jan 20, 1923, and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Arteno Sclerosis -
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) William H Knight, M. D.

Jan 21, 1923 (Address) 1209 P Rd Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Jan 23 1923

20 UNDERTAKER: John H Owens — ADDRESS: 5-38 Eutaw St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71503

CERTIFICATE OF DEATH.

100-001 D71503

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1224 So. Edward St. or Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Marie V. Baltzer

(Residence in Baltimore: No. 1224 So. Edward ave St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Oct (Month) 11 (Day) 19 (Year)

7-AGE.	If LESS than 1 day,
3 yrs. 11 mos. ds.	....hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Joseph Baltzer

11-BIRTHPLACE OF FATHER. (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER. Marie Parka

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Baltzer

(Address) 1224 So. Edward ave

15-JAN 23 1923 ROBERT R. KRAUTER,

Filed..... 192..... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 22 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

192... (Address) .....

*State the Disease Causing Death, or, In Deaths from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Louis Cem	Jan 29 1923

20-UNDERTAKER.	ADDRESS
Stephen Kralkowski	1005 Fremont

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71504

CERTIFICATE OF DEATH.

101-001 D71504

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1609 W. Franklin St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Churn Braxton

(a) RESIDENCE NO. 1609 W. Franklin St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Braxton

6 DATE OF BIRTH (month, day, and year) 3/12/1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46.	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Private family

(c) Name of employer Levering

9 BIRTHPLACE (city or town) (State or country) Nassawadox Va.

PARENTS

10 NAME OF FATHER Walter Churn

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Hampton Co. Va.

12 MAIDEN NAME OF MOTHER Peggie Javis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Hampton Co. Va.

14 Informant (Address) Hallie Churn, Daughter,. 1609 W. Franklin St

15 JAN 23 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15th. 19..., to Jan. 21. 1923. 19...

that I last saw her alive on Jan. 20th. 1923, 19...

and that death occurred, on the date stated above, at 2:30 A.Mam.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Bilateral)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Influenza (Epidemic)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1610 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dove Church Va. DATE OF BURIAL Jan 22 1923

20 UNDERTAKER Jane A. Dunn ADDRESS 300 Fredrick

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71505

D71505

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Elizabeth Home ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Monument

(a) RESIDENCE. NO. St. Elizabeths Home Chestnut St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	negro	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Foundling

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		about 4 mos	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Foundling Institution

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant

(Address)

15 Filed JAN 23 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21 1923

17 I HEREBY CERTIFY, That I attended deceased from December 18, 1922, to January 20, 1923, that I last saw him alive on January 20, 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis - Varicella

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Jan 21, 1923 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19 JAN 23 1923
JOHNS HOPKINS HOSPITAL	ADDRESS

20 UNDERTAKER Pauper Burial

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

20

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71506

CERTIFICATE OF DEATH. 161-001 D71506

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 70 WARD)

2-FULL NAME Betty Collins

(a) RESIDENCE No. (3752) 3752 Colonial Av. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Jan 24 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Wm. Collins

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Granville

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant William A. Atkins (Address) 3752 Colonial Ave

15 FILED JAN 23 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-21-1923

17 I HEREBY CERTIFY, That I attended deceased from 1-21-1923, to 1-21-1923.

that I last saw him alive on 1-21-1923,

and that death occurred, on the date stated above, at 11 40 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia both lungs.

about 7 mos.

..... (duration) ..... yrs. ..... mos. 2 wks 3 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Surgical aid Date of 1/21/23

Was there an autopsy? no

What test confirmed diagnosis? Clin. findings.

(Signed) Newton S. Dan, M. D.

1/23/1923 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 25 1923

20 UNDERTAKER	ADDRESS
Geo. L. Schwab	2101 Eutaw Pl.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71507

CERTIFICATE OF DEATH.

148

D71507

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hospital (ST.) 20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida Atkins

(a) RESIDENCE NO. 3752 Culver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William A. Atkins

6 DATE OF BIRTH (month, day, and year) Oct. 21-1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Glanville

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Kate Parks

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant William A. Atkins (Address) 3752 Culver St

15 Filed JAN 23 1923, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22-1923

17 I HEREBY CERTIFY, That I attended deceased from 1-20-, 1923, to 1-22-, 1923, that I last saw her alive on 1-22-, 1923 and that death occurred, on the date stated above, at 8 20 a m.

The CAUSE OF DEATH* was as follows:

Acute nephritis c

uremia & Pregnancy

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Newton D Cron, M. D.

1-22, 1923 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 25 1923
20 UNDERTAKER	ADDRESS
George L. Schwab	801 Cath. Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71508 D71508

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Homewood Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2724 Charles ST., 16 WARD)

2-FULL NAME Wm J. Cunningham

(a) RESIDENCE NO. 646 N Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of:

6 DATE OF BIRTH (month, day, and year): May 1st 1852

7 AGE: Years 70 Months 8 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Mortimer Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Martha Forney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Wm Southall

(Address): 646 N Carey St

15 JAN 23 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany. 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15th, 1922, to Jany 21st, 1923, that I last saw him alive on Jany. 20th, 1923, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arterio-sclerosis

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Uraemia

(Signed) Otelia F. Stellman M. D.

, 19 (Address) 1227 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Jan 23 1923

20 UNDERTAKER: Wm J. Richardson

ADDRESS: Balto MR

Spec.—1-10-21—M&T—1500 Bks.

D71509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71509

CERTIFICATE OF DEATH.

91-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2248 E. Hoffman ST., 8 WARD)

2-FULL NAME Susie Allen Cammann

(a) RESIDENCE No. 2248 E. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates. MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm A. Cammann

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 66				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Glen Allen Va

PARENTS

10 NAME OF FATHER: J. M. Sheppard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Virginia Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Wm A. Cammann

(Address) 2248 E. Hoffman St

15 JAN 23 1923 ROBERT M. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 18th 23 to Jan 20th 23,

that I last saw h[illegible] alive on Jan 20th 23,

and that death occurred, on the date stated above, at 3.10 P m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Stone M. D.

Jan 22 19 23 (Address) 1501 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Jan 23 1923

20 UNDERTAKER: Wm Fickus & Sons — ADDRESS: North Ave

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71510

CERTIFICATE OF DEATH.

101-001 D71510

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Kropp

(a) RESIDENCE NO. 861 S. Dallas St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Francis Kropp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Elizabeth Karia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Municipal Hospital Records.

(Address)

15 JAN 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 21 19 23

17

I HEREBY CERTIFY, That I attended deceased from January 16, 19 23, to January 21 19 23,

that I last saw him alive on January 21, 19 23,

and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Sign

(Signed) Clyde McNeil, M. D.

1/22/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus. Bcm. DATE OF BURIAL: Jan. 24 1923

20 UNDERTAKER: M. J. Sadowski. ADDRESS: 905 S. Arnold

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71511 CERTIFICATE OF DEATH. 162 D71511

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135 W. Preston ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Oliver

(a) RESIDENCE. NO. 135 W. Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19 1923

7 AGE Years Months Days If LESS than 1 day, 11 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Albert Oliver

11 BIRTHPLACE OF FATHER (city or town) Savannah
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Mabel Preston

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant
(Address)

15 Filed JAN 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1923, to Jan 20, 1923, that I last saw h.i.m alive on Jan 20, 1923, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) T. Norwood Wilson M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS

Commissioner of Health.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

31

0065

D71512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 D71512

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1131 E. Lexington ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Worden

(Residence in Baltimore: No. ? St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 21 about ....yrs....mos....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country).

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

JAN 23 1923 191... ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Jan 12 ....., 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....Inquest.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)
Inquest .....find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....
Asphyxia by Illuminating Gas
.....
..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.
(Coroner.)
Jan 12, 1923 (Address) 1139 E Lex

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	....., 19....
20-UNDERTAKER	ADDRESS
MORGUE	

Commissioner of Health.
Per Wm. E. Woodall
JAN 23 1923

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71513

CERTIFICATE OF DEATH.

100-001

D71513

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 1803. Frederick Ave ST., 19 WARD)

2-FULL NAME James W. O'Malley.

(a) RESIDENCE NO. 1803. Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 11th 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James J. O'Malley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Emma Romm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mr. James J. O'Malley.

(Address) 1803 Frederick Ave

Filed JAN 23 1923

ROBERT R. KRAUTER,

Burial Permit Clerk.

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22nd 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1923. to Jan 21, 1923.

that I last saw him alive on Jan 21, 19

and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 14 ds.?

CONTRIBUTORY (Secondary)

(duration) yrs. mos. over ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. Keller Hemming M. D.

1/23 1923 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Jan 24 1923
20 UNDERTAKER	ADDRESS
John F. Cowan & Son	901 Hollins
per F. J. Cowan	St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71514

CERTIFICATE OF DEATH.

113 D71514

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 918 Burgundy ST., 21 WARD)

2-FULL NAME Charles N Opperman

(a) RESIDENCE NO. 918 Burgundy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6 1922

7 AGE: Years | Months: 2 | Days: 16. | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Edgar Opperman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Nellie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mr Edgar Opperman

(Address): 918 Burgundy St

15 Filed JAN 23 1923, 19 ROBERT B. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22nd, 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-16-, 1923, to 1-22-, 1923, that I last saw h[illegible] alive on Jan 22, 1923, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Impaired Feeding

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Jan 24 1923

20 UNDERTAKER: John J. Cowan & Son — ADDRESS: 901 Hollins

John J. Cowan

50

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Sposito

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71515

CERTIFICATE OF DEATH.

129

D71515

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) 271 East St. (St.) 5 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvator Sposito

(a) RESIDENCE. NO. 271 East St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosario Sposito

6 DATE OF BIRTH (month, day, and year) 5/12/1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Importer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Salvatore Sposito

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mariarina Siciliano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Paolo Vitale (Address) 271 East St.

15 Filed JAN 23 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Cert.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Jan 21, 1923, that I last saw him alive on Jan 21, 1923, and that death occurred, on the date stated above, at 10 15 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis with Calculi (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of 1/19/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. C. Marino, M. D.

(Address) 1300 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 24 1923

20 UNDERTAKER George - & Ruth ADDRESS 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71516

CERTIFICATE OF DEATH.

44 D71516

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 East ST., 5 WARD)

2-FULL NAME Gaetano Lo Presti

(a) RESIDENCE NO. 314 East ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: Carmella Scandaliato

6 DATE OF BIRTH (month, day, and year): Nov 28 - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer): 840

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Carmelo Lo Presti

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Liboria Fontana

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Carmella Lo Presti

(Address) 314 ~~East St~~

JAN 23 1923 ROBERT H. KINGUTER,

Filed , 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922, to Jan 21, 1923,

that I last saw h~~e~~ alive on Jan 21, 1923

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. Di Stefano M. D.

Jan 23, 1923 (Address) 407 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: 1/24 1923

20 UNDERTAKER: George J. Ruth — ADDRESS: 1705 Harford Ave

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

(Truelove)

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71517

CERTIFICATE OF DEATH.

57 D71517

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospital ST. 8 WARD)

2-FULL NAME Mrs Catherine Truelove

(a) RESIDENCE NO. 2011 E Fayette St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. A. Truelove.

6 DATE OF BIRTH (month, day, and year) 8/1/1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Kate A. Roth (Address) 2011 E. Fayette

15 Filed JAN 23 1923 ROBERT R. KRAETER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/21/1923

17 I HEREBY CERTIFY, That I attended deceased from 12/4/1923 to 1/21/1923, that I last saw h[illegible] alive on 1/21/1923 and that death occurred, on the date stated above, at 12 55 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Geo A Tompkins M. D.

. 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Jan. 25 1923

20 UNDERTAKER George F. Roth ADDRESS 1735 Harford

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71518 CERTIFICATE OF DEATH. 189-003 D71518

1-PLACE OF DEATH Pronounced Dead at Registered No. C.....

City of BALTIMORE: (No. Franklin Square Hospital 20 X Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Margaret Morning

(Residence in Baltimore: No. 419 N. Brice St. St.; yrs. 1 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~ Married ~~Widowed or Divorced~~, (Write the word.)

6-DATE OF BIRTH. Sept (Month) 19th (Day) 1885 (Year)

7-AGE. 37 yrs. 4 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... At Home
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE, (State or Country). Ohio

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mamie Sauder

(Address) 419 N. Brice St.

15-

JAN 23 1923 19... ROBERT R. KRAMER, Registrar.

~~Burial Permit Clerk.~~

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 21 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigations (Inquest, autopsy or inquiry.) find that said deceased came to hers death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture L arm accidental

Shock Internal Hemorrhage

Contusions accident

(Duration) Instant yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jesse M. Emerson M. D. (Coroner.)

Jan 22 1923 (Address) 700 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted, if not at place of death?.....

Former or usual residence Ohio

19-PLACE OF BURIAL OR REMOVAL, Cincinnati Ohio DATE OF BURIAL, Jan 24 1923

20-UNDERTAKER, Rae B. Evans & Son ADDRESS 1100 N. Royal Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71519

CERTIFICATE OF DEATH.

46 D71519

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 Hayward Ave. ST., 27 WARD)

2-FULL NAME Elizabeth Halter

(a) RESIDENCE NO. 621 Hayward Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Halter.

6 DATE OF BIRTH (month, day, and year) June 1 1853

7 AGE: Years 69; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Martin Weikert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mrs Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Christian Halter

(Address) 621 Hayward Ave

15 Robert P. Mar? 18th, 19

Registrar

Burial Permit Clerk.

JAN 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July —, 1922, to Jan 21, 1923,

that I last saw her alive on Jan 20, 1923,

and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Cancer Uteri

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination only

(Signed) C B Evans, M. D.

1-22 1923 (Address) 5016 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: 1-24 1923

20 UNDERTAKER: Mrs Chas A G Rohde ADDRESS: 600 Marlington ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71520 D71520

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4704 Charles Ave ST., 27 WARD)

2-FULL NAME Geo W. Browne

(a) RESIDENCE No. 4704 Charles Ave ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Kate A. Browne

6 DATE OF BIRTH (month, day, and year) Sept 6 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Abraham Browne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Hatton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. W. L. Grier
(Address) 4704 Charles Ave

JAN 23 1923 , 19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 , 1923 , to Jan 22 , 1923 ,
that I last saw him alive on Jan 22 , 1923 ,
and that death occurred, on the date stated above, at 12 15 A m.

The CAUSE OF DEATH* was as follows:

(Bronchial)? Carcinoma
Myocardial degeneration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis + Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Clarence Jones M. D.

1-22 19 23 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Jan 24 1923

20 UNDERTAKER H. C. Wiedefeld

ADDRESS 914 Greenmount Ave

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

8.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

JAN 23 1923

D71521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D71521

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2202 Poplar Grove St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Latimer S. Gleisner

(Residence in Baltimore: No. 2202 Poplar Grove St. about 15 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (~~Write the word.~~)
Male	White	Married

6-DATE OF BIRTH, July 11, 1873 (Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Druggist
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Chas. Gleisner

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Elizbeth Roberts

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Gleisner Wife

(Address) 2202 Poplar Grove

15-

Robert P. Harrison, M.D.

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 22, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Jan 23, 1923 (Address) 200 Redwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Jan 24, 1923

20-UNDERTAKER, William Cook — ADDRESS 502 E Pratt

HEALTH DEPARTMENT---CITY OF BALTIMORE

D71522 D71522

CERTIFICATE OF DEATH

46

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 5104 Wilson Ave Ward 37 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Minnie F. Fortie,

(Residence in Baltimore: No. 5104 Wilson Av. Arlington St.; 40 yrs. ... mos. ... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Oct (Month) 29 (Day), 1871 (Year)

7-AGE: 52 yrs. 4 mos. — ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): No 8

9-BIRTHPLACE (State or country): Balto. Co. Md.

PARENTS

10-NAME OF FATHER: Geo. L. Fortie

11-BIRTHPLACE OF FATHER (State or country): Balto. Md

12-MAIDEN NAME OF MOTHER: Elizabeth Gompton

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William F. Fortie

(Address) 5104 Wilson Ave

15- Robert P. Harrison, 191

JAN 23 1923

Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Jan. (Month) 22 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 3 1922, to, Jan 22 1923, that I saw h.. alive on Jan. 20 1923, and that death occurred, on the date stated above, at 12.15 pm.

The CAUSE OF DEATH* was as follows:

Carcinoma of the uterus, and metastasis to the peritoneum

Abdl (Duration) 1 yrs — mos. — ds.

Contributory (SECONDARY) ... (Duration) ... yrs ... mos ... ds.

(Signed), Charles Gelb M. D.

Jan. 22 1923 [Address] 1111 W. Lanvale St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: Jan 26 1923

20-UNDERTAKER: George J. Smith

ADDRESS: 1532 Hollins

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71523

CERTIFICATE OF DEATH.

7H-001 D71523

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 908 N. Arlington ave St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Mettee Jones

(Residence in Baltimore: No. 908 N. Arlington ave St.; 47 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Feby. (Month) 5 (Day), 1876 (Year)

7-AGE, 46 yrs. 11 mos. 18 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Ezekiel Jones

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co. Md

12-MAIDEN NAME OF MOTHER Sophia Catherine Bandel

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. E. Martin.

(Address) 4126 Forest Park ave

15-

Filed ..... Robert P. Harrison
Registrar.

JAN 23 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 21st (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 14th 1923, to January 21st 1923, that I saw h[illegible] alive on January 21st 1923, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) — yrs. — mos. 7d ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

..... (Duration) — yrs. — mos. 14 ds.

(Signed) Hallam F. Stillman M. D.

Jany 22, 1923 (Address) 1727 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Jan. 24, 1923
20-UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71524

CERTIFICATE OF DEATH.

129

D71524

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 St. Fulton Ave St.; 20 WARD)

2-FULL NAME. Robert J. Royston

(a) RESIDENCE. No. Home for the Aged of the M. E. Church St.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) July 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto county Md

PARENTS

10 NAME OF FATHER Robert Royston

11 BIRTHPLACE OF FATHER (city or town) Balto Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Bowers

13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country) Maryland

14 Informant Helen E. Bennett (Address) 400 N Fulton ave Home for Aged

15 Filed JAN 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1922, to Jany 22, 1923, that I last saw him alive on Jany 20, 1923, and that death occurred, on the date stated above, at 8.15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Endocarditis (duration) ✓ yrs. 4 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) George C. Shannon M. D.

1/23 1923 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park cemetery	June 2 1923

20 UNDERTAKER George J Gratke ADDRESS 1532 Hanover st

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—1000 Blks.

D71525 HEALTH DEPARTMENT—CITY OF BALTIMORE D71525

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1118 Riggs Ave ST.: 16 WARD)

2-FULL NAME James William Telghman

(a) RESIDENCE. No. 1118 Riggs ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colrd	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beaulah Telghman

6 DATE OF BIRTH (month, day, and year) Dec 14. 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer J. C. Linthicum

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George William Telghman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co. Md

12 MAIDEN NAME OF MOTHER Mary Virginia Simms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Beaulah Telghman
(Address) 1118 Riggs Ave.

15 Filed JAN 23 1923 19 Robert F. Harrison Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1922, to Jan 22, 1923, that I last saw h. alive on Jan 22, 1923, and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic ?

(duration) yrs. 6 ? mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical Urinary

What test confirmed diagnosis?

(Signed) William H Wright, M. D.

Jan 22, 1923 (Address) 1709 Preston Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Jan 25 1923

20 UNDERTAKER ADDRESS

George H. Holland 1631 Druid Hill Ave

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71526

CERTIFICATE OF DEATH.

187-007

1-PLACE OF DEATH Pronounced, Dead at — Registered No. C.....

City of BALTIMORE: (No Maryland Insanity Hospital 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Michael Ferenc

(Residence in Baltimore: No. 1211 S Decker Ave St. yrs. 1 mos. ds.)

WRITE PLAINLY.—WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 23 1923

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1..... (Year)

7-AGE, 26 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Reveter
(b) General nature of industry, business, or establishment in which employed (or employer). 086

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, Andrew Ferenc

11-BIRTHPLACE OF FATHER, (State or Country). Austria

12-MAIDEN NAME OF MOTHER, Cessa Strabo

13-BIRTHPLACE OF MOTHER, (State or Country). Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Ferenc

(Address) 1211 S. Decker Ave

15- Filed ..... 192.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 20 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Subdural Hemorrhage

Accident

(Duration) Sudden yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H. Hamilton M. D. (Coroner)

Jan 23 1923 (Address) 100 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Jan 24 1923

20-UNDERTAKER, Frank Groetzinger — ADDRESS 700 Gilmor Jan 24 1923

T 4180

Remarks. Well near factory

From Machinery

Injured by Machinery

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71527 ✓ 1855 ✓ D71527

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., ✓ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Woodward O'Hara

(a) RESIDENCE NO. Adamstown Md ST., WARD Adamstown Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie O'Hara

6 DATE OF BIRTH (month, day, and year): Aug 8-1859

7 AGE: Years 63 Months 5 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): U. H.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records

15 Filed ..., 19... Robert P. Harrison, Registrar

Burial Permit Clerk.

JAN 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 23rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24 1922 to Jan. 23 1923 that I last saw h in life on Jan 23rd 1923 and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

accidental traumatic rupture of urethra

(over)

(duration) yrs. mos. 4½ ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage

(duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of Nov 24th

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) G. C. Talley M. D.

1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Adamstown Md. C. M. ✓ DATE OF BURIAL ... 1923

20 UNDERTAKER: Eastman Hoke ADDRESS Frederick Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Accidental fall from Wagon

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

O'Ca by
Dr. Storsuck,
Coroner
H. K. Brocket
Coroner M. D.

Spec.—1-10-21—M&T—1500 Bks.

D71528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 74-101

D71528

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 N. Charles St. St., 12 WARD)

2-FULL NAME Margaret Cunningham Healy

(a) RESIDENCE NO. 2213 N. Charles St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
Abt. 65 years				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Matthew Healy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Anna M. Healy

(Address) 2213 N. Charles St.

15 Filed JAN 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21" 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. ....., 1922, to Jan 21, ..., 1923.

that I last saw h alive on Jan 21, ..., 1923.

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

~~Acute Pneumonia~~

arteriosclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) ~~Acute Pneumonia~~

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. T. Hennessy, M. D.

1/22 19 2 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL Jan. 24" 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bond St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71529

CERTIFICATE OF DEATH.

101-001

D71529

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 331 - E 30th St. 17 WARD)

2-FULL NAME George Henry Rogers

(a) RESIDENCE. NO. 331 - E. 30th ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~) of Sarah Rogers

6 DATE OF BIRTH (month, day, and year) Aug-26-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Sea Food Products

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Somerset Co. (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maranda Thorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant George Milton Rogers Son
(Address) 2016 E. 24th St.

15 Filed JAN 23 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1923

17 I HEREBY CERTIFY, That I attended deceased from last Jan 15, 1923, to Jan 22, 1923, that I last saw h~~is~~ alive on Jan 21st 1923, and that death occurred, on the date stated above, at 9:40 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Ch. Nephritis (duration) ~~one~~ yrs. ~~one~~ mos. ~~one~~ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Spencer Buck M. D.

1/22 1923 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 24 1923

20 UNDERTAKER J E Myers ADDRESS 1111 N Broadway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2844 St Paul St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71530

CERTIFICATE OF DEATH.

101-001

D71530

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 N. Gilmor ST., 15 WARD)

2-FULL NAME Mrs Ida Elizabeth Henry

(a) RESIDENCE No. 1310 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: William Scott Henry

6 DATE OF BIRTH (month, day, and year): Dec. 15-1858

7 AGE: Years 64 Months 1 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: self

037

9 BIRTHPLACE (city or town) (State or country): Delaware

PARENTS

10 NAME OF FATHER: James Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Sarah Ralph

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Delaware

14 Informant: Mrs Hadie Disharoon (daughter)

(Address) 1310 N. Gilmor St

15 Robert P. Harrison, Registrar

JAN 23 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22nd 1923

17

I HEREBY CERTIFY That I attended deceased from Jan 19th, 1923, to Jan 22nd, 1923,

that I last saw her alive on Jan 22nd, 1923,

and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) L. L. Gordy, M. D.

1-23 1923 (Address) 718 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Delmar, Delaware

DATE OF BURIAL: Jan 24 1923

20 UNDERTAKER: H. E. Hughes

ADDRESS: 4th & Broadway

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71531

CERTIFICATE OF DEATH.

129

D71531

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3411 Cedardale Rd ST., 15 WARD)

2-FULL NAME James Harry Livingston

(a) RESIDENCE NO. 3411 Cedardale Rd ST., 15 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Anna E. Livingston

6 DATE OF BIRTH (month, day, and year): June 27-1844

7 AGE — Years: 78 Months: 6 Days: 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Druggist

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. city Md

PARENTS

10 NAME OF FATHER: Seth F. Livingston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Nancy Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Anna E. Livingston

(Address): 3411 Cedardale Road

15 Filed: Jan 25 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1923, to Jan 23, 1923.

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

acute Heart failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Chronic Myocarditis & Nephritis

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical examination

(Signed) Wm. H. Harryman, M. D.

, 19 (Address) 3409 Cedardale Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Jan 25 1923

20 UNDERTAKER: W. J. Tichnell & Son

ADDRESS: Walbrook

JAN 23 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71532

CERTIFICATE OF DEATH.

D71532

REGISTERED NO. 100-601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2224 Washington Blvd ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Waren H. Mosberger

(a) RESIDENCE NO. 2224 Washington Blvd. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6—1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City (State or country) Md

PARENTS

10 NAME OF FATHER Howard Mosberger

11 BIRTHPLACE OF FATHER (city or town) Balto City (State or country)

12 MAIDEN NAME OF MOTHER Lottie Hoyer

13 BIRTHPLACE OF MOTHER (city or town) Balto City (State or country)

14 Informant Lottie Mosberger

(Address) 2224 Washington Blvd

15 Filed JAN 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-21, 1923, to 1-21, 1923, that I last saw him alive on 1-21-, 1923, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

congestion of lungs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W B Hall, M. D.

, 19 (Address) Halethorpe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 24 19 23

20 UNDERTAKER: W. J. Tichnell & Son — ADDRESS: Wath

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Mrs Hall
Washington Road
Probably Bronchio
Pneumonia

Spec.—1-10-21—M&T—1500 Bks.

(See affadivit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71533

D71533

CERTIFICATE OF DEATH.

118-002

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME Dora Pass

(a) RESIDENCE NO. 2122 Presbury St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE ~~58~~ 48 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

037

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Samuel Reidel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rosa Epstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Rose Pass (daughter)

15 Robert F. Harrison, Registrar

JAN 23 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 21, 1923, to Jan 22, 1923,

that I last saw h[illegible] alive on Jan 22, 1923,

and that death occurred, on the date stated above, at 2:20 P.m.

The CAUSE OF DEATH* was as follows:

Acute intestinal obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Paralysed paralytic

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of Jan 21, 23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin B. Jarrett, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brooklyn N. Y.

DATE OF BURIAL: Jan 24 1923

20 UNDERTAKER: J. Ahrens & Co

ADDRESS: 1611 Mad[illegible]

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Personally appeared before me this 1st. day of Februar
1923, Miss Rose Pass, and made affadavit that the age
given on Death Certificate D-71533 as 58 years is incorrect,
same should be 48 years.

Rose Pass.
Daughter,

Subscribed and Sworn to before me this 1st. day of
February, 1923.

Rud Gaither
Notary Public

(avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71534

D71534

CERTIFICATE OF DEATH. 49

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hospital ST.; 9 WARD)

2-FULL NAME Mary Redmond.

(a) RESIDENCE. NO. 2042 Harford Rd - WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Redmond.

6 DATE OF BIRTH (month, day, and year) Aug 6th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
51				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Alice O'Donnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant John Redmond (Address) 2042 Harford Ave

15 Filed JAN 23 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6 1922 to Jan 22 1923.

that I last saw h alive on Jan 22 1923.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (duration) mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Pancreas (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) John A. Schmuck M. D.

(Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer.	Jan 25th 1923

20 UNDERTAKER Leo G. Cook ADDRESS North & Harford

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D71535

CERTIFICATE OF DEATH.

43 D71535

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin St. Hosp. ST., 19 WARD)

2-FULL NAME Jacob Fidley

(a) RESIDENCE No. 1513 W. Mulberry ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa J.

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE: Years 67 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Policeman, Ret.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

161

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: William

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

Informant: Daughter Belle Fidley Keidel

(Address): 1513 W. Mulberry St

15 Filed JAN 24 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-22-1923

17

I HEREBY CERTIFY, That I attended deceased from Dec-11-, 1922, to Jan-22, 1923,

that I last saw him alive on Jan. 22-, 1923,

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of jaw with metastasis (Lung)

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Kenton S. Fam, M. D.

1-22, 1923 (Address) Franklin St. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 1/24/1923

20 UNDERTAKER: John O Mitchell — ADDRESS: 1701 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D71536

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D71536

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 E 22d ST., 9 WARD)

2-FULL NAME Frances Ann Walker

(a) RESIDENCE No. 509 E 22d St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? allway yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~; (write the word) ~~Married~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest S. Walker

6 DATE OF BIRTH (month, day, and year) Febr 12 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Briscoe Wm H.

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Sarah Owen

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Cora Lee Krebs

(Address) 509 E 22nd St.

15 Filed JAN 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22d 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1922 to Jan 22, 1923

that I last saw h[er] alive on Jan 22, 1923

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Gall Bladder

Carcinoma

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Internal Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination + Symptoms

(Signed) Joseph E Gichner, M. D.

, 19 (Address) 1516 Madison av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Jan 24 1923

20 UNDERTAKER: John O Mitchell — ADDRESS: 1251 W Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

Dr. Feldner 1501 E. Eager.

D71537

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002 D71537

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1700 E. Lanvale ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Tienken

(a) RESIDENCE. No. 1708 E. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E.

6 DATE OF BIRTH (month, day, and year) 8/3/1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman: Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Sarah Dubell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Sadie D. Tienken (Address) 1700 E. Lanvale St

15 JAN 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 22, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922 to January 22, 1923 that I last saw h alive on January 22 1923 and that death occurred, on the date stated above, at 10.05 P. m.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Feldner, M. D.

January, 19 23 (Address) 1501 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Jan. 25, 1923

20 UNDERTAKER John O. Mitchell ADDRESS 1701 W. Fayette St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71538

CERTIFICATE OF DEATH.

129 ✓ D71538

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 1608 Harlem Ave ST. 16 WARD)

2-FULL NAME. Sarah J. Pyle

(a) RESIDENCE. NO. 1608 Harlem Av ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E Pyle

6 DATE OF BIRTH (month, day, and year) Apr 30, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chestnut Hill Md

PARENTS

10 NAME OF FATHER James H Delevett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda J. Bull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) James H Pyle Guilford Park. Md

15 JAN 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1923

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1919, to Jan 20, 1923, that I last saw h[illegible] alive on January 20, 1923, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & microscopic Ex.

(Signed) J. M. Delevett, M. D.

Jan 24, 1923 (Address) 621 Washington Boulevard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Deer Creek Md.	Jan 24 1923
20 UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71539

CERTIFICATE OF DEATH.

90 D71539

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ben Snowden

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'K D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 JAN 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 19 23

17

I HEREBY CERTIFY, That I attended deceased from November 19 19 18 to January 21 19 23

that I last saw h. im alive on January 20 19 23

and that death occurred, on the date stated above, at 5:50 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

1/23/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL 1/24/23

20 UNDERTAKER John B Tradwin ADDRESS 1429 N Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D71540

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71540

CERTIFICATE OF DEATH.

118-002

1-PLACE OF DEATH. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1010 E. Preston St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Sugerman

(Residence in Baltimore: No. 1010 E. Preston street St.; 35 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1861 (Year)

7-AGE: 61 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E. Baltimore

15-

Filed JAN 24 1923 191.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 23rd (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 21 1923, to Jan 23 1923, that I saw her alive on Jan 23 1923, and that death occurred, on the date stated above, at 5 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Interstinal Obstruction

(Duration) 20 yrs. ..... mos. ..... ds.

(Signed) Ernest Edlavitch M. D.

1-23-23 1923 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. 3 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mehren Rosedale — DATE OF BURIAL, 1-24-1923

20-UNDERTAKER Jack Lewis — ADDRESS 1439 E Baltimore

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71541

CERTIFICATE OF DEATH.

47 V D71541

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 W 38th St. 13 WARD)

2-FULL NAME Ida Ann Frank

(a) RESIDENCE NO. 1022 W 38th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F Frank

6 DATE OF BIRTH (month, day, and year) Jan 17 1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
57	X	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry H F

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John F Frank

(Address) 1022 W 38th St

15 Filed JAN 24 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1922, 19, to Jan 23, 19 23.

that I last saw h.er alive on Jan 23, 19 23.

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of R. Breast

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 1922

Was there an autopsy? no

What test confirmed diagnosis? Rab.

(Signed) Raleworth M. D.

1/24, 1923 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Carroll Co. DATE OF BURIAL Jan 26 1923

20 UNDERTAKER Chenowith & Son ADDRESS Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71542

CERTIFICATE OF DEATH.

D71542

REGISTERED NO. 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1636 N. Gilmor (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Gaines

(a) RESIDENCE. NO. 1636 N. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Gaines

6 DATE OF BIRTH (month, day, and year): May 15-1874

7 AGE: Years 3 | Months 8 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Work

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): County Galway Ireland

PARENTS

10 NAME OF FATHER: Patrick Gaach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Galway Ireland

12 MAIDEN NAME OF MOTHER: Mc Nurra

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Galway Ireland

14 Informant (Address): William Gaines 1636 N. Gilmor St

15 Filed JAN 24 1923 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1923 to Jan 22nd, 1923, that I last saw her alive on Jan 22nd, 1923, and that death occurred, on the date stated above, at 4 55/11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) one yrs. six mos.

CONTRIBUTORY (Secondary): General Arteriosclerosis

(duration) three yrs. mos.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? yes Date of June 1922

Was there an autopsy? no

What test confirmed diagnosis? microscopical

(Signed) Wm J Sullivan M. D.

1/23 1923 (Address) 1701 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: Jan 26 1923

20 UNDERTAKER: Martin Fickey Son

ADDRESS: 1821 N North

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Deceased was admitted
into the Hospital
July 1922 for
Carcinoma of Heart
the Tumor was removed
by [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71543 ..

CERTIFICATE OF DEATH.

90 D71543

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 N. Fulton ave. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Mertz

(a) RESIDENCE. No. 306 N. Fulton ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sabastian Mertz

6 DATE OF BIRTH (month, day, and year) Apr 18th 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER — Seigried

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Mertz

(Address) 306 N. Fulton ave

15 Filed JAN 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1923, to Jan 22, 1923

that I last saw h alive on Jan 22, 1923

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Hennessy, M. D.

Jan. 23, 1923 (Address) 210 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Jan 25 1923
20 UNDERTAKER	ADDRESS
F. A. Frame & Son	737 Hanover St

D71544

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71544

CERTIFICATE OF DEATH.

Registered No. C 170

1-PLACE OF DEATH

City of BALTIMORE: (No. 2101 Division St., St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Jackson

(Residence in Baltimore: No. 2101 Division St. St.; yrs. 18 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: July (Month) 31 (Day) 1894 (Year)

7-AGE: 31 yrs. 6 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country): Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Alice Jackson

13-BIRTHPLACE OF MOTHER, (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theresa Bryant

(Address) 533 W. Mt. McKewin St

15-

Filed JAN 24 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 22 (Day) 1923. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gun shot wound in Head.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Instantaneous Death.

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Jan. 23, 1923. (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-NAME OF CEMETERY OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Jan 24, 1923
20-UNDERTAKER.	ADDRESS
Edward Ringgold	1413 N. Carey St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D71545

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71545

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 809 W. Cross ST., 21 WARD)

2-FULL NAME Thomas J. Heffernan

(a) RESIDENCE NO. 809 W. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie M. Heffernan

6 DATE OF BIRTH (month, day, and year) Nov. 28 1844

7 AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or .. min.
	78	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant George T. Heffernan
(Address) 809 W. Cross St.

15 Filed JAN 24 1923, 19 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2 1923 to Jan 22 1923

that I last saw him alive on Jan. 22 1923

and that death occurred on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical

(Signed) M. C. Trigg M.D.

1/24 1923 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Jan 25 1923

20 UNDERTAKER James Tipman & Son

ADDRESS 1000 S. Pacca St

Spec.—1-10-21—M&T—1500 Bks.

Williams

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71546 ✓ 44 D71546

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 Argyle Ave. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry William

(a) RESIDENCE NO. 1105 Argyle Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Florence Williams

6 DATE OF BIRTH (month, day, and year) March 9-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of Industry, business, or establishment in which employed (or employer): ( ) 086

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Estella Williams

(Address): ~~11~~ 5207 Denmore

15 JAN 24 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 22, 1923, that I last saw ~~her~~ alive on Jan 21, 1923, and that death occurred, on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

about 6 mo

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach about 6 mo

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? X Ray

(Signed) W. B. Liebold, M. D.

Jan 23/23 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Jan 25-1923

20 UNDERTAKER: Mrs Robert F Elliott

ADDRESS 1725 Ashland Ave

Spec.—8-24-14—M. & T.—2000 Bks.

O'Brien

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D71547

D71547

CERTIFICATE OF DEATH.

90

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 N. Central Ave ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Albrieu

(Residence in Baltimore: No. 613 N. Central Ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	C	Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1868. (Year)

7-AGE, 54 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Daniel Albrieu

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Albrieu (daughter)

(Address) 613 N. Central Ave

15-

Filed....., 191.....

JAN 24 1923

Registrar.

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 22., 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 14 1923, to Jan 22 1923, that I saw him alive on Jan 22 1923, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(Duration) ....yrs. ....mos. ....ds.

(Signed) R. J. Young M. D.

1/27, 1923. (Address) 1424 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Jan. 26, 1923

20-UNDERTAKER Mrs. A. A. Elliott

ADDRESS 172 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Remarks No other history

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71548

CERTIFICATE OF DEATH.

101-001 D71548

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1517 E Madison ST.; 7 WARD)

2-FULL NAME Lorenza D James

(a) RESIDENCE. No 1517 E madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER George James

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Sarah Baily

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Stanley James
(Address) 1517 E Madison St

15 Filed JAN 24 1923 19 ROBERT R. KNAUTH, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1923, to Jan 23, 1923, that I last saw h[illegible] alive on Jan 23, 1923, and that death occurred, on the date stated above, at 4.15 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

History of Influenza

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) R Edward Fisher M. D.

1-23 1923 (Address) 607 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pocomoke City Md — DATE OF BURIAL Jan 25 1923

20 UNDERTAKER J. J. H. Rochester — ADDRESS 1403 Wmead

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71549

CERTIFICATE OF DEATH.

128 D71549

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 934 Bennett Pl ST.; 18 WARD)

2-FULL NAME Edna E. Stenneman

(a) RESIDENCE NO. 934 Bennett Place ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 10 mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 5, 1877

7 AGE Years 42 Months 10 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Ger. Stenneman

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Lillenthal

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mellin Stenneman

(Address) 934 Bennet Pl.

15 JAN 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1923, to Jan 23, 1923, that I last saw h alive on Jan 22, 1923 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute Bright's Disease (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Uraemic Coma

(Signed) John A Evans, M. D.

, 19 (Address) 101 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Jan 26 1923

20 UNDERTAKER Ruff & Little ADDRESS 2700 Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal Condition

D71550

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71550

CERTIFICATE OF DEATH.

90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 825 St Paul St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Florence Seems

(Residence in Baltimore: No. 825 St Paul St.; yrs. 30 mos. ..... ds.)

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced (Write the word.) Married

6-DATE OF BIRTH, May (Month) 21 (Day) 1874 (Year)

7-AGE, 48 yrs. 8 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). Home 037

9-BIRTHPLACE, (State or Country). White Hall Deer Foot Farm

PARENTS.

10-NAME OF FATHER, Charles Clemmey

11-BIRTHPLACE OF FATHER, (State or Country), White Hall,

12-MAIDEN NAME OF MOTHER. Lucy Lemmey

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Seems

(Address) 825 St Paul

15- Filed JAN 24 1923 192.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 24 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Heart

Sudden (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Mitchell M. D.

Jan 24 192 3 (Coroner.) (Address) 1609 E Baltimore

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cem — DATE OF BURIAL, Jan 26th 1923

20-UNDERTAKER, Leo G. Cook — ADDRESS Bath & Harford

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71551

D71551

160

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1031 E. 3rd St ST., 26 WARD)

2-FULL NAME Anna F. Micheal

(a) RESIDENCE NO. 1031 E. Third ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 5. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
		1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Geo. Micheal

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Georgiana Grebner

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs. Micheal
(Address) 1031 E. 3rd.

15 JAN 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21 1923, to Jan. 23 1923, that I last saw alive on Jan. 22 1923 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Mal-nutrition

(duration) ..... yrs. 1 mos. 18 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. D. Iker, M. D.

1/23/1923 (Address) 408 S Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Jan 25 1923
20 UNDERTAKER	ADDRESS
Stephen J. Fialkowski	1000 S. Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71552

CERTIFICATE OF DEATH.

38 D71552

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Brown

(a) RESIDENCE NO. 232 S. Durham St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1892

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
31	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Job Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Lucy Burdon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto., Md.

14 Informant: Municipal Hospital Records. (Address)

15 JAN 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 21 1923

17

I HEREBY CERTIFY, That I attended deceased from January 19, 1923 to January 21, 1923.

that I last saw her alive on January 20, 1923,

and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Reported

What test confirmed diagnosis? Clinical & X-ray

(Signed) Clyde McNeil M. D.

1/22/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Jan 24 1923

20 UNDERTAKER: Edward Bryan

ADDRESS: 1631 Orleans

Spec.—1-10-21—M&T—1500 Blks.

D71553

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71553

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH Universit Hospital · 19 REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Blakstone

(a) RESIDENCE NO. 1415 Cairo St., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant University Hospital Records.

(Address)

15 FILED JAN 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/29, 1922, to Jan 21, 1923,

that I last saw him alive on Jan 21, 1923,

and that death occurred, on the date stated above, at 8 a; m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) W Boerner, M. D.

1-21, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Furnace Branch A & Co — DATE OF BURIAL Jan 24 1923

20 UNDERTAKER Wm. H. Chase Son — ADDRESS 1401 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D 71554

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 71554

CERTIFICATE OF DEATH.

11-00'

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 Brunt ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie L. Slaughter

(a) RESIDENCE NO. 1526 Brunt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur R. Slaughter

6 DATE OF BIRTH (month, day, and year) Dec 11-1894

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
28 -	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Mr Strasser

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Groome

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Arthur R. Slaughter (Address) 1526 Brunt

15 JAN 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 22 1923

17

I HEREBY CERTIFY, That I attended deceased from January 14th, 1923, to January 22, 1923, that I last saw h.e alive on January 22, 1923, and that death occurred, on the date stated above, at 1650 m.

The CAUSE OF DEATH* was as follows:

Influenza (duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion and Pleurisy (duration) 1 yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward E. Mackenzie, M. D.

(Address) 1309 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 1-24 1923

20 UNDERTAKER George H. Holland

ADDRESS 1621 Hanover Street

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not I. B.

Silvia Carraro

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71555

CERTIFICATE OF DEATH.

45 D71555

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hosp. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sebé Carraro

(a) RESIDENCE. NO. 1003 Stirling ST., 10 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ~ mos. ~ ds. How long in U. S., if of foreign birth? 16 yrs. ~ mos. ~ ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 24 1923

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Carraro

6 DATE OF BIRTH (month, day, and year) March 1 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work File setter

(b) General nature of industry, business, or establishment in which employed (or employer) and Cementer 082

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Louis Carraso

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Mary Carraso

(Address) 1003 Stirling St

15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1923 to Jan. 24, 1923 that I last saw him alive on Jan. 24, 1923 and that death occurred, on the date stated above, at 9:05 a.m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan. 17-23

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Bernard Dreso, M. D.

, 19 (Address) 414 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Jan. 27 1923

20 UNDERTAKER Henry Hoeck Son ADDRESS 1301 E Eager

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D71556

D71556

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 N. Central Ave ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Zimmerman

(Residence in Baltimore: No. 811 N. Central ave St.; 68 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, August (Month) 18 (Day), 1847 (Year)

7-AGE, 75 yrs. 5 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Carpenter

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Zimmerman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Angeline Zimmerman

(Address) 811 N. Central Ave.

15-

Filed....., 191.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk

JAN 24 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 22 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 1923, to Jan 22 1923, that I saw him alive on Jan 22 1923, and that death occurred, on the date stated above, at 2.50 p.m.

The CAUSE OF DEATH* was as follows:

.....
Cerebral Hemorrhage
.....
..... (Duration) ...yrs. ...mos. 10 ...ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

..... (Duration) 5 yrs. ...mos. ...ds.

(Signed) C. E. Husband M. D.

1/22, 1923. (Address) Hopkins Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Jan 20, 1923

20-UNDERTAKER Henry Hoch & Son

ADDRESS 130 E Eager St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D71557 HEALTH DEPARTMENT—CITY OF BALTIMORE D71557

CERTIFICATE OF DEATH. 74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 759 W Lexington ST., 4 WARD)

2-FULL NAME Nicoli Mazzatrulli

(a) RESIDENCE NO. 759 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adelaide Mazzatrulli

6 DATE OF BIRTH (month, day, and year): Jan 17-1873

7 AGE: Years 50 Months — Days 6 If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 180

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Adelaide Mazzatrulli

(Address): 759 W Lexington St

15 JAN 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 22nd, 1923, to Jan 23rd, 1923, that I last saw h[illegible] alive on Jan 23rd, 1923 and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. Testa, M. D.

, 19 (Address) 240 Park av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Jan 27 1923

UNDERTAKER: John Nellis

ADDRESS: 2105 Eutaw

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Usink)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71558

D71558

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N. Six. ST., 25 WARD) Brooklyn

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christena Usink

(a) RESIDENCE No. 108 N Six ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Usink

6 DATE OF BIRTH (month, day, and year) Nov 24 1840

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
83	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Dont Know (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Dont Know (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know (State or country) Germany

14 Informant Mrs Wm H. Ford. (Address) 108 N Six st Brooklyn Md

15 JAN 24 1923 19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 3rd, 1923, to Jan 23rd, 1923, that I last saw h[illegible] alive on Jan 22nd, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Acute.

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Negative previous history

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 409 S. Eden St.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Stethoscope

(Signed) Robert W Johnson, M. D.

, 19 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL Jan 26 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D71559

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 120

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME Joseph M Howard

(a) RESIDENCE NO. 115 E Montgomery St ST., WARD California Mo

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 days mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of Ethel Howard

6 DATE OF BIRTH (month, day, and year) Oct 1-1887

7 AGE: Years 35 Months 3 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10 NAME OF FATHER Henry B Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Missouri

12 MAIDEN NAME OF MOTHER Anna Broeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Missouri

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Robert F. Harrison, Registrar

JAN 24 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4- 1923, to Jan 20 1923.

that I last saw him alive on Jan 20 - 1923,

and that death occurred, on the date stated above, at 4.55 P m.

The CAUSE OF DEATH* was as follows:

Acute yellow atrophy of Liver

(duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Multiple abscesses of Liver

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Johns Hopkins Hosp

Did an operation precede death? No Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) Chas LeBurg, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL California, Missouri Via American Ry Express

DATE OF BURIAL Jan 25 1923

20 UNDERTAKER John F. Denny

ADDRESS 715 Light

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71560

CERTIFICATE OF DEATH.

90 D71560

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Mens Home Calhoun & Lexington Sts ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Broders

(a) RESIDENCE NO. Aged Mens Home ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 20 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co

PARENTS

10 NAME OF FATHER Edward Broders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth A Keene

13 BIRTHPLACE OF MOTHER (city or town) Cambridge (State or country) Maryland

14 Informant Henrietta Broders (Address) Aged Womens Home Miss Harriet N. Gillman Matron

15 Robert P. Harrison, Registrar

JAN 24 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 , 1923 , to Jan 23 , 1923 ,

that I last saw h alive on Jan 22 , 1923 ,

and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis of Heart

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Hoswood M. D.

Jan 23 1923 (Address) 937 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Jan 25 1923
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

WRITE IN INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Ticky)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71561

D71561

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 N. Castle ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Ticky

(a) RESIDENCE NO. 928 N. Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if of foreign birth? 53 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) Sept 23, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Stuart & Co.

9 BIRTHPLACE (city or town) (State or country) Bohemia Europe

PARENTS

10 NAME OF FATHER Andrew Ticky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia Europe

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia Europe

14 Informant Mary Ticky

(Address) 928 N. Castle st

15 Filed Robert P. Harrison, Registrar

JAN 24 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922 to January 23 1923.

that I last saw him alive on January 23, 1923.

And that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Hemorrage of Brain

one year ago and

present attack Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas J Simms, M. D.

, 19 (Address) 1025 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 26 1923
20 UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71562 45 D71562

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2111 Hollins St. 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Denia Burns

(a) RESIDENCE. No. 2111 Hollins St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? 20 yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E. Burns

6 DATE OF BIRTH (month, day, and year) Oct 6 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Cornick Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Lavin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas E. Burns
(Address) 2111 Hollins St.

15 Filed JAN 24 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1923

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1922 to Jan 22, 1923.

that I last saw her alive on Jan 22, 1923.

and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum, recurring 9 months after Operation

(duration) Over 10 mos. ✓ ds.

CONTRIBUTORY ✓ (Secondary)

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of About May 1-22

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Tile, M. D.

Jan 22 1923 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	1/25/23
20 UNDERTAKER	ADDRESS
Geo. E. Farley	Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71563

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D71563

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2768 Fenwick Ave. St., 20 Ward)

2-FULL NAME William H. Sheeler

(a) RESIDENCE No. 2768 Fenwick Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura V. Sheeler

6 DATE OF BIRTH (month, day, and year): Mar. 15, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brush maker

(b) General nature of industry, business, or establishment in which employed (or employer): 186

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER: Anthony Sheeler

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER: Mary Bullard

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) .....

14 Informant: Laura V. Sheeler

(Address) 2768 Fenwick Ave

15 Filed: Robert F. [illegible] Registrar

JAN 24 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1922, to Jan 21st, 1923, that I last saw h[illegible] alive on Jan 21st, 1923 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Fleiss Steele M.D.

1/23 1923 (Address) 2844 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Jan 25, 1923

20 UNDERTAKER: William Cook — ADDRESS: 502 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71564

CERTIFICATE OF DEATH.

REGISTERED No. C 47 D71564

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hosp St. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. S.)

2-FULL NAME Emma Dr. E. Allister

(Residence in Baltimore: No. Horn Bldg. Lexington St. 27 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	white	

6-DATE OF BIRTH, ..., 1865.
(Month) (Day) (Year)

7-AGE, 58 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE (State or Country) England.

PARENTS.

10-NAME OF FATHER, Thos. Palmer

11-BIRTHPLACE OF FATHER (State or Country) England

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. H. McAllister

(Address) 2345 W. Fayette St

15- Robert F. Harrison, Registrar.

JAN 24 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 23, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer breast

5 yrs. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

(Signed) Luther T. Bay M. D.
(Coroner.)

Jan 24, 1923 (Address) 1003 E. Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL Loudon Park

DATE OF BURIAL, Jan. 25, 1923.

20-UNDERTAKER Marshall Hayes & Co.

ADDRESS 827 N. North Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D71565

CERTIFICATE OF DEATH.

D71565

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Francis Xavier School for the Deaf

CITY OF BALTIMORE: (No. Woodland & Irvington ST.: 28 WARD)

2-FULL NAME Sister Mary Elizabeth Clifford

(a) RESIDENCE. No. St. Francis Xavier School for the Deaf ST., Old Frederick Road WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, ~~Married, Widowed, or Divorced (write the word)~~: Single

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 31 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York City NY

PARENTS

10 NAME OF FATHER: Edward Clifford

11 BIRTHPLACE OF FATHER (city or town) (State or country): No record

12 MAIDEN NAME OF MOTHER: Ellen Brenen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): No record

14 Informant: Sister M. Stephen Harding

(Address) St Francis Xavier School for Deaf

15 Filed JAN 24 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1923, to Jan 23, 1923, that I last saw her alive on Jan 23, 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) W. A. Knell, M. D.

1/24, 1923 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 1-26-1923

20 UNDERTAKER: Henry W. Jenkins Sons Co.

ADDRESS: Orchard & McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71566

CERTIFICATE OF DEATH.

D71566

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4802 Pimlico Rd ST. 27 WARD)

2-FULL NAME Effie Hartman Ford

(a) RESIDENCE NO. 4802 Pimlico Rd ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John F Ford

6 DATE OF BIRTH (month, day, and year): March 21 1862

7 AGE — Years: 60 — Months: 10 — Days: 2 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Wm Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Mary Reib

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Mr James B Butler New Haven Conn

15 AN 24 1923 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1923, to Jan 23, 1923, that I last saw h[illegible] alive on Jan 23, 1923, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D Butler, M. D.

, 19 (Address) 4854 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: Jan 25 1923

20 UNDERTAKER: Wm J Tickner & Son — ADDRESS: Woodlawn Md

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. John Burnett
Park Ave & Woodland Ave
Not L. B.

Spec.—1-10-21—M&T—1500 Bks.

(Miehe)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71567

D71567

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav Mirke

(a) RESIDENCE NO. 363 N. Calvert ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna K. Mirke

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) W.C. Mirke Edgewood Ave Govd Dist Govd Ave Catonsville Md

15 Filed ..... 19 ..... Registrar Robert P. Harrison, Burial Permit Clerk.

JAN 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/20 1923.

17 I HEREBY CERTIFY, That I attended deceased from 1/15, 1923, to 1/20, 1923, that I last saw h[illegible]alive on 1/20, 1923 and that death occurred, on the date stated above, at 6[19] A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis with Stokes Adams syndrome.

(duration) 3. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of .....

Was there an autopsy? yes. clinical

What test confirmed diagnosis? autopsy

(Signed) Leon Tredon, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Jan 25 1923

20 UNDERTAKER Geo M. Frick & Son ADDRESS 811 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D71568

D71568

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1011 Greenmount Ave ST.; 10 (WARD)

2-FULL NAME Frank Chiofalo.

(a) RESIDENCE. NO. 1011 Greenmount Ave ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male Italian	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28. 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Gaspare Chiofalo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Antonia Scandalato

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Gaspare Chiafalo

(Address) 1011 Greenmount Ave

15 JAN 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Jan 23, 1923, that I last saw h alive on Jan 23, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Anaemia - Hydrocephalus

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) William H Wright, M. D.

Jan 24, 1923 (Address) 1709 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Geo. H. Ruth. DATE OF BURIAL Jan 25 1923

20 UNDERTAKER Holy Redeemer Cem. ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D71569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 D71569

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2229 Division ST., 14 WARD)

2-FULL NAME Margaret Ellen Samuels

(a) RESIDENCE NO. 2229 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 2, 1870

7 AGE: Years 7 Months 6 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Samuels.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Ellen Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs. Samuels (Address) 2229 Division St.

15 Filed JAN 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to Jan 22, 1923.

that I last saw her alive on Jan 22, 1923.

and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred D Jewett M. D.

Jan 23 1923 (Address) 2516 Penn ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: JAN. 25 1923.

20 UNDERTAKER: Charles H. Dellis

ADDRESS 303 Fremont

Spec.—1-10-21—M&T—1500 Blks.

D71570

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71570

1922
30

CERTIFICATE OF DEATH. X101-001 842

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Jones

(a) RESIDENCE NO. 55 Lawrence St. WARD Ungiven

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S. if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Madison Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hannah Mayfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Phil Jones
(Address) 2143 N Carey St

15 Filed JAN 25 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 17th 1923 to Jan 24th 1923.

that I last saw him alive on Jan 24th 1923

and that death occurred, on the date stated above, at 9.45A m.

The CAUSE OF DEATH* was as follows:

Lobar-Pneumonia

(duration) 1 yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 55 Laurens St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Harry F Brown M. D.

1/24 1923 (Address) 150 Fresstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rockwell Mem. Gdns. Va	Jan 25th 1923

20 UNDERTAKER Hammond Wright & Co

ADDRESS 364 N Carey

D71571

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-001

D71571

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hard. Pen. R.R. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Becker

(Residence in Baltimore: No. 412 E. Biddle St.; yrs. 39 mos. 11 ds. 25)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, January (Month) 26 (Day) 1883 (Year)

7-AGE. 39 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER, George Becker

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Emma Boss

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Becker

(Address) 412 E Biddle st

15- JAN 25 1923 192.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 24 (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract skull - (Other injuries)

Shock by car of Pa. R.R. Co. Accident

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

.....(Duration) ....yrs. ....mos. ....ds.

(Signed) M. J. Riley M. D.

(Coroner.)

Jan 25 1923. (Address) 1639 Reading

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Jan 26th 1923

20-UNDERTAKER, George Schilling & Sons

ADDRESS 426 E Monument

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71572

CERTIFICATE OF DEATH.

10 D71572

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., (WARD)

2-FULL NAME Richard Boswell.

(a) RESIDENCE NO. 512 N. Schroeder ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb — 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	11	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Boswell

11 BIRTHPLACE OF FATHER (city or town) Elkridge
(State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Allen

13 BIRTHPLACE OF MOTHER (city or town) Centreville
(State or country) Md

14 Informant Wm. N. Boswell
(Address) 512 N. Schroeder St

15 Filed JAN 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit (Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1923, to Jan 24, 1923, that I last saw him alive on Jan 24, 1923, and that death occurred, on the date stated above, at 9:05 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) B. MacGowan, M. D.

1/25/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview

DATE OF BURIAL 1-25-1923

20 UNDERTAKER H. C. Brauning Son

ADDRESS 517 N Schroeder St

Spec.—1-10-21—M&T—1500 Bks.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71573

99-002D71573

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 N. Fremont ST., 17 WARD)

2-FULL NAME Frederick C. Fugle

(a) RESIDENCE NO. No. 911 N. Fremont ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., If of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella G. Fugle

6 DATE OF BIRTH (month, day, and year) Sept 26 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Samuel Fugle

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Agatha Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Ella G. Fugle
(Address) 911 N. Fremont Ave

15 FILED JAN 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1922, to Jan 23, 1923, that I last saw him alive on Jan 21, 1923, and that death occurred, on the date stated above, at 1230 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis, and Progressive Asthenia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) 6 yrs. ~~mos~~ 6 hours

18 Where was disease contracted if not at place of death? Back

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Phys. diagnosis

(Signed) Robert W. Mifflin, M. D.

1/23 1923 (Address) No. 1016 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL Jan. 25 1923

20 UNDERTAKER John O. Mitchell 1120 W. Fayette — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71574

CERTIFICATE OF DEATH.

100-001

D71574

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3602 Old Frederick Rd. ST., 20 WARD)

2-FULL NAME Virginia Colfelt

(a) RESIDENCE NO. 3602 Old Frederick Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 24/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

00

9 BIRTHPLACE (city or town) Baltimore, Md

(State or country) ~~Middletown Va~~

PARENTS

10 NAME OF FATHER Harry P Colfelt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Middletown Va

12 MAIDEN NAME OF MOTHER Lillian Kroft.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md

14 Informant Harry P Colfelt

(Address) 3602 Old Fred Rd

15 Filed JAN 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1923

17

I HEREBY CERTIFY, That I attended deceased from January 11, 1923 to January 22, 1923.

that I last saw her alive on January 22, 1923,

and that death occurred, on the date stated above, at 2 15 a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edward Nevolusan, M. D.

1/23 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Lawn Park Cemetery DATE OF BURIAL JAN 25 1923

20 UNDERTAKER F. B. Stuppert ADDRESS 2256 Frederick Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

D71575 HEALTH DEPARTMENT—CITY OF BALTIMORE D71575

74-001

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Josephs Hosp St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Joseph Marine

(Residence in Baltimore: No. 149 Rogers Ave St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Unknown, 1..... (Month) (Day) (Year)

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Lowman 040

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Marine

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Smith

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Nicholas (Mrs.)

(Address) 236 N. Ann St

JAN 25 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 22 192.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

(Signed) J. H. Collins M. D. (Coroner.)

1-24 1923 (Address) 1 S. E. Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn cemetery DATE OF BURIAL. Jan 24 192.

20-UNDERTAKER. Edward Bryson ADDRESS 1631 Orleans St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71576

CERTIFICATE OF DEATH.

100-001 D71576

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2101 Belair Road ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia L. Mitten

(a) RESIDENCE. No. 2101 Belair Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Noah Mitten

6 DATE OF BIRTH (month, day, and year) Aug 20/1832

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	90	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER — Unit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Asked Not Known

12 MAIDEN NAME OF MOTHER Asked Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Asked Not Known

14 Informant (Address) Mrs James Callahan 2101 Belair Road

15 Filed JAN 25 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 24 1923.

17 I HEREBY CERTIFY, That I attended deceased from January 18, 1923, to January 24, 1923.

that I last saw her alive on January 23, 1923.

and that death occurred, on the date stated above, at 1.05 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. 2 mos. 6 ds.

CONTRIBUTORY (secondary) Broncho pneumonia and Exhaustion (duration) yrs. mos. 3 ds.

18 Where was disease contracted, if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) Albert Edsell M. D.

, 19 (Address) 2027 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ~~St Mary's Right Field~~ Baltimore Cemetery DATE OF BURIAL Jan 27 1923

20 UNDERTAKER A. S. Marshall ADDRESS 3039 Falls Rd

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1749872 90 D71577

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 2 WARD)

2-FULL NAME Mr. Henry F. Lambdin

(a) RESIDENCE NO. 2004 E. Bank St, City ST., ... WARD [redacted]

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Processor Can Co.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Lambdin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Boland

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed JAN 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 1923, to Jan 23 1923, that I last saw him alive on Jan. 23, 1923, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Carbuncle

(duration) 8 yrs. — mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? Balto city

Did an operation precede death? Yes Date of 1-19-23

Was there an autopsy? Yes. 1-21-23

What test confirmed diagnosis? Autopsy findings

(Signed) Myron E. Goldblatt, M. D.

1-23, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 26 1923
20 UNDERTAKER	ADDRESS
H. Sanders & Sons	1710 Eutaw St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71578

CERTIFICATE OF DEATH.

44 D71578

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 S. Linwood Ave. ST., / WARD) .....

2-FULL NAME Rebbeca A. West.

(a) RESIDENCE NO. 819 S. Linwood Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar A. West

6 DATE OF BIRTH (month, day, and year) Nov. 25-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Martin Luther

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Oscar A. West
(Address) 819 S Linwood ave

15 Filed JAN 25 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Jan 24, 1923, that I last saw h-e alive on Jan 24, 1923 and that death occurred, on the date stated above, at 7 40 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Tutton, M. D.

1/25, 1923 (Address) 315 S. Highland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL Jan 26 1923

20 UNDERTAKER H. Standen & Sons — ADDRESS 210 Park Ave

Dr. McAvoy

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71579

CERTIFICATE OF DEATH.

129

D71579

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 S. Potomac ST., 1 WARD)

2-FULL NAME Marie C. Kellner

(a) RESIDENCE NO. 1114 S. Potomac ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward A. Kellner

6 DATE OF BIRTH (month, day, and year): Feb. 1, 1836.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: John Wauski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Frank Huber
(Address) 1114 S. Potomac St.

15 FILED JAN 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 24, 1923.

that I last saw h[illegible] alive on Jan 24, 1923

and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —No

What test confirmed diagnosis? —

(Signed) M J McAvoy, M. D.

Jan 25, 1923 (Address) 839 S. Ellwood Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul's Cemetery	Jan 26 1923
20 UNDERTAKER	ADDRESS
A. Sander & Sons	1710 Thames St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71580

CERTIFICATE OF DEATH.

117 D71580

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 Myrtle Ave ST., 17 WARD)

2-FULL NAME Clementine Thomas

(a) RESIDENCE NO. 1105 Myrtle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Oct 7 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
33	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Charles Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Chaney Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Chaney Thomas

(Address): 1105 Myrtle Ave

15 Filed JAN 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22-1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1923, to Jan 21, 1923, that I last saw h[illegible] alive on Jan 21, 1923, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Superative Appendicitis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1105 Myrtle Ave

Did an operation precede death? yes Date of Dec 9

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jas C Carper, M. D.

, 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 26 1923
20 UNDERTAKER	ADDRESS
Jno Robert A Elliott	Ashland Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71581 | 101-00 | D71581

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 650 Aull ST.: 17 WARD)

2-FULL NAME Gertrude Olivia

(a) RESIDENCE. NO. 650 Aull ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe | 4 COLOR OR RACE: Col | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William Olivia

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Ruby Scott

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant William Olivia
(Address) 650 Aull St

ROBT. F. KRAUTER,
Burial Permit Clerk.

15 Filed JAN 25 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1923, to Jan 25, 1923
that I last saw her alive on Jan 25, 1923
and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) P. Gaul Schmidt, M. D.

1923 (Address) 1534 E. H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lamsdale Cemetery	Jan 27, 1923
20 UNDERTAKER Mrs Robert F. Elliott	ADDRESS 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71582

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-101

D71582

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1216 N. Parrish St. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Bernard Harris

(Residence in Baltimore: No. 1216 N. Parrish St. St.; yrs. 4 mos. 9 ds. 7)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced. (Write the word.) single

6-DATE OF BIRTH, April 14, 1923
(Month) (Day) (Year)

7-AGE, 6 yrs. 9 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Charles Harris,

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Emma Nolan

13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chas. Harris

(Address) 1216 N. Parrish St.

15- Filed JAN 25 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 23, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration)....yrs....mos. 5 ds.

CONTRIBUTORY (Secondary) no history

(Duration)....yrs....mos....ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Jan. 23 1923 (Address) 2802 Edgewood Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, 1-25-23

20-UNDERTAKER, Daniel Easter ADDRESS 911 E. Lane

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D71583

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D71583

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 347 S Mount ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Ridgely

(Residence in Baltimore: No. 347 S Mount St — St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Jan 25, 1923 (Month) (Day) (Year)

7-AGE, ...yrs. ....mos. ....ds. If LESS than 1 day, 3 hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto md.

PARENTS.

10-NAME OF FATHER, Guilford Sudler Ridgely

11-BIRTHPLACE OF FATHER (State or Country), Howard Co, Md.

12-MAIDEN NAME OF MOTHER Mary Henrietta Dickman

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. D. Ridgely

(Address) 347 S. Mount St

15-

JAN 25 1923. 191. ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 25, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 25 1923, to Jan 25 1923, that I saw h[illegible] alive on Jan 25 1923, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

6 Mos Gestation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Marshall G. Smith M. D.

Jan 25, 1923 (Address) 118 N Calhoun St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel md.	1/24, 1923.
20-UNDERTAKER Robert Brohkeem	ADDRESS Calhoun ST HOLLINS ST

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71584

CERTIFICATE OF DEATH.

74 D71584

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Gilliam H. Sumpter

(Residence in Baltimore: No. 1912 E Biddle St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

6-DATE OF BIRTH. Oct (Month) 25 (Day) 1921 (Year)

7-AGE. 1 yrs. 2 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto md

PARENTS.

10-NAME OF FATHER. Geo W Sumpter

11-BIRTHPLACE OF FATHER, (State or Country). Balto md

12-MAIDEN NAME OF MOTHER. Mary A. Tultzer

13-BIRTHPLACE OF MOTHER, (State or Country). Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W. Sumpter

(Address) 1912 E. Biddle St

15-Filed JAN 25 1923 No. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 24 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Tetanus.

(No Autopsy - not necessary)

only in Hospital 2 hrs (Duration) ...yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

.....(Duration) ...yrs.....mos.....ds.

(Signed) J. S. H. Collins M. D. (Coroner.)

1-24 1923 (Address) 506 E North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. Loudon Park — DATE OF BURIAL. 1/26 1923

20-UNDERTAKER. Wm Cook — ADDRESS 502 E North

Spec.—1-10-21—M&T—1500 Bks.

Dr C They

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71585

CERTIFICATE OF DEATH.

X 129 ✓ D71585

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 S. Clinton St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma E. Slaughter

(a) RESIDENCE NO. 118 S. Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Robert H. Slaughter

6 DATE OF BIRTH (month, day, and year): July 22 1857

7 AGE: Years 64; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Levin H. Parlett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah E. Hahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Robert H Slaughter

(Address) 118 S. Clinton

15 JAN 25 1923 ROBERT N. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 19 1923 to Jany 23 1923

that I last saw h[illegible] alive on Jany 23 1923

and that death occurred, on the date stated above, at 6 20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb K They, M. D.

Jan 24, 1923 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Md

DATE OF BURIAL: 1/25 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 562 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71586 HEALTH DEPARTMENT—CITY OF BALTIMORE D71586

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4102 Penhurst Ave. 2E WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Florence Dembeemer

(a) RESIDENCE NO. 4102 Penhurst Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myron Dembeemer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Bates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susie Stuffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Myron Dembeemer

(Address) 4102 Penhurst Ave

15 Filed JAN 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 18, 1923, to Jan 24, 1923, that I last saw her alive on Jan 24, 1923, and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) acute dilatation of heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. Frederick Lentz, M. D.

Jan 24, 1923 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chevra Shalom Cemetery DATE OF BURIAL Jan 26/1923

20 UNDERTAKER J. Ahrens & Les ADDRESS 1611 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71587 D71587

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 W. Cross ST. 21 WARD)

2-FULL NAME Dorothy Barney

(a) RESIDENCE. NO. 509 W. Cross ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	Col,	Sin.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 19-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER James Barney

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Ella, Indc
Md

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant James Barney
(Address) 509 W. Cross St

15 Filed JAN 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 19th, 1923, to Jan 24, 1923, that I last saw her alive on Jan 24th, 1923, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

about 21
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D H. Carwell, M. D.

1923 (Address) 1400 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct	Jan 26 1923
20 UNDERTAKER	ADDRESS
S. L. Brown & Son	1080 W. Mont'y

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71588 D71588

CERTIFICATE OF DEATH.

90

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 Gilman Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Katherine Schofield

(Residence in Baltimore: No. 536 Gilman Ave St.; ....yrs., ...mos. ....ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb 1, 1865 (Month) (Day) (Year)

7-AGE, 57 yrs. 11 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Stitcher
(b) General nature of industry, business, or establishment in which employed (or employer) Hat trimmings

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Henry Schofield

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Barbara E. Dames

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice C. Schofield

(Address) 536 Gilman Ave

15- JAN 25 1923 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. (Month) 22 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 5 1922, to Jan 22 1923, that I saw h[er] alive on Jan 22 1923, and that death occurred, on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ....yrs. 8 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) C.W. Waddell M. D.

1/24/23, 191... (Address) 321 E 35

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Mary's Evans | DATE OF BURIAL, Jan 25, 1923

20-UNDERTAKER E. A. Wiedefeld & | ADDRESS 501 E 22nd St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71589

CERTIFICATE OF DEATH.

129 D71589

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2106 Dalbrook Ave ST., 11 WARD)

2-FULL NAME Wade Hampton Body

(a) RESIDENCE NO. 715 W Baredway ST., WARD 7

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Gray.

6 DATE OF BIRTH (month, day, and year) Oct 22 62

7 AGE 60 Years 3 Months 2 Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pilot 36

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm T. Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs Gray 2106 Dalbrook Ave.

15 JAN 25 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Jan 25, 1923, that I last saw h(im)alive on Jan 25, 1923, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Several Years (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Goitre Throat

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Chas E Tanker M. D.

, 19 (Address) 2106 Dalbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 1/29 1923

20 UNDERTAKER Wm Cook

ADDRESS 1502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71590

CERTIFICATE OF DEATH.

X 49 ✓ D71590

REGISTERED NO.

1-PLACE OF DEATH Provd & Kelly Hosp

CITY OF BALTIMORE: (No. 1418 Eutaw Place ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. J. Brooks May

(a) RESIDENCE. NO. ..... ST., ... WARD. Sawyersville Ala!

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vic E. May

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hale Co Ala
(State or country) Alabama

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Albert May
(Address) Greensboro Alabama

15 Filed JAN 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923, to Jan 24, 1923, that I last saw h[illegible] alive on Jan 24, 1923 and that death occurred, on the date stated above, at 9 12 8 m.

The CAUSE OF DEATH* was as follows:

Carcinoma kidney

(duration) yrs. 3 mos. 24 ds.

CONTRIBUTORY (Secondary) None (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X ray + urine

(Signed) Grant Edward, M. D.

, 19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sawyersville Alabama — DATE OF BURIAL: Jan 25 1923

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave.

D71591

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-004 D71591

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 614 N Calvert St.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mateo N. Jeffers Jr.

(Residence in Baltimore: No. 614 N. Calvert St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	W	Married

6-DATE OF BIRTH, Feb 8, 1877.
(Month) (Day) (Year)

7-AGE, 25 yrs. 11 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Steward
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, Mateo N. Jeffers

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Katie E. VanArsdale

13-BIRTHPLACE OF MOTHER (State or Country), Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mateo N. Jeffers Sr.

(Address) 317 N. Paca St.

15- Filed JAN 25 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 22, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia by Streptococcus
Duration 2 days

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)
Jan 24, 1923 (Address) 1057 Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, Jan 26, 1923

20-UNDERTAKER Chas. G. Black

ADDRESS 742 W. Fourth ave

Spec.—1-10-21—M&T—1500 Bks.

Griner ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71592

CERTIFICATE OF DEATH.

74-001 D71592

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3440 Ruxleston Road (ST.) 5 (WARD)

2-FULL NAME Sophia Griner

(a) RESIDENCE NO. 3440 Ruxleston Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Ntv yrs. 19 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or~~ WIFE of John A Griner

6 DATE OF BIRTH (month, day, and year) Dec 9-1851

7 AGE Years 71 Months Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West River Md

PARENTS

10 NAME OF FATHER Conrad Kirchner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Kirchner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant H. M. Griner (Address) 3440 Ruxleston Rd

15 Filed JAN 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1922, to Jan. 24, 1923, that I last saw h-e alive on Jan 24, 1923, and that death occurred, on the date stated above, at 5:10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laby Clinic

Signed Grafton Jones Brown, M. D.

1-24-23 (Address) 1837 Eutaw pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West River Md. DATE OF BURIAL Jan 27 1923

20 UNDERTAKER Cook & Turner ADDRESS 1472 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D71593

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71593

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1917 E Hayette ST., 6 WARD)

2-FULL NAME Concetta Savarese

(a) RESIDENCE NO. 1917 E Hayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Michael Savarese

6 DATE OF BIRTH (month, day, and year): Dec 8-1863

7 AGE: Years: 59 | Months: | Days: | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: M. Savarese

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Michael Savarese

(Address): 1917 E Hayette

15 Filed JAN 25 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/22 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/22, 1923, to 1/22, 1923,

that I last saw h.. alive on 1/22, 1923,

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Jinberg M. D.

1/24, 1923 (Address) 1802 E. Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer County

DATE OF BURIAL: Jany 1923

20 UNDERTAKER: Robt J Turner

ADDRESS: 14 N. Bway

Spec.—1-10-21—M&T—1500 Bks.

Eugene J. Kankos. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

71594

CERTIFICATE OF DEATH.

159-002 D71594

1-PLACE OF DEATH Belmont Ave.

CITY OF BALTIMORE: No. 528 N. Belnord St., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene John Kankos.

(a) RESIDENCE NO. 528 N. Belnord ST., WARD

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 1/9/23

7 AGE: Years — Months — Days 16 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Frank Kankos.

11 BIRTHPLACE OF FATHER (city or town) Austria (State or country)

12 MAIDEN NAME OF MOTHER Mary Petios.

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Frank Kankos (Address) 528 N. Belnord

15 Filed JAN 25 1923 ROBERT B. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25 19 23.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 9, 19 23, to Jan 24, 19 23.

that I last saw h[illegible] alive on Jan 25, 19 23.

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease. ✓

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Bronchitis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. H. Meyer Jr. M. D.

1/25, 19 23 (Address) 1638 E Balto ✓

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 25 19 23

20 UNDERTAKER Emil Engelhardt — ADDRESS 1906 Gough

Spec.—6-9-19—B. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71595 | 129 D71595

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) St. Joseph's Hospe. ST.: 26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henery Lindenberger (Henry J. Linberger)

(a) RESIDENCE. NO. 926 First St. ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Linberger

6 DATE OF BIRTH (month, day, and year) Sept. 30-1869.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electro - Plater.

(b) General nature of industry, business, or establishment in which employed (or employer): Wm. J. Eisenhardt

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. md.

PARENTS

10 NAME OF FATHER Theobold Linberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER Johanna Bruggraf

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant (Address): Christina Linberger 926 S. First St

15 JAN 25 1923 19..

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1923, to Jan 23, 1923.

that I last saw him alive on Jan 22, 1923.

and that death occurred, on the date stated above, at 5:50 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S

(Signed) John J. Krager, M. D.

, 19 (Address) St. Joseph's Hospe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Jan. 26 1923
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT READING, PAGE 2, and information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Claude L. Howard) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71596

CERTIFICATE OF DEATH. 11-001

D71596

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 4 N Carey — ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claude L Howard —

(a) RESIDENCE. No. 4 N Carey — ST., 19 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of 27 Dec 1873

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 609

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bessie A Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Bessie A. Howard (Address) 4 N. Carey St.

15 Filed JAN 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25/23. 19

17 I HEREBY CERTIFY, That I attended deceased from 12/20/22, 19, to 1/25/23. 19, that I last saw h alive on 1/24/23. 19, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Influenza.

(duration) yrs. mos. 5 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F W Wenzel, M. D.

1/25/23. 19 (Address) 1302 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond VA	Jan 27 1923

20 UNDERTAKER	ADDRESS
Josiah Lyper	1600 N North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71597

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71597

CERTIFICATE OF DEATH.

1-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hosp St., 17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm E. Carter

(a) RESIDENCE NO. 507 W-28th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 13 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of industry, business, or establishment in which employed (or employer) School child

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Maurice Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Lydia E. Sims

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co.

14 Informant Maurice Carter

(Address) 507 W. 28th Street

15 Date 19

Burial Permit Clerk. Registrar

JAN 25 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/24/23

17 I HEREBY CERTIFY, That I attended deceased from 12/22/22, 19 ..., to 1/24/23, 19 ..., that I last saw h alive on 1/24/23, 19 ..., and that death occurred, on the date stated above, at 4-30 a.m.

The CAUSE OF DEATH* was as follows

Typhoid Fever.

(duration) yrs. mos 47 ds.

CONTRIBUTORY (Secondary) Cardiac Syndrome

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat & Clyne Test

(Signed) H.O. Applegarth, M. D.

19 (Address) 1417 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Providence Cemetery Balto Co

DATE OF BURIAL: Jan 26 1923

UNDERTAKER: John Burns Sons

ADDRESS: Towson Md

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71598 63 D71598

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Hanover ST., 23 WARD)

2-FULL NAME Sarah E. Berryman

(a) RESIDENCE No. 1125 Hanover ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. P. Berryman

6 DATE OF BIRTH (month, day, and year) Jan. 11, 1885

7 AGE: Years 38 | Months — | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Phillip E. Dulany

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mexico

12 MAIDEN NAME OF MOTHER Sarah Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Wm. P. Berryman
(Address) 1125 ~~Hanover St~~ ROBERT F. [illegible]

15 JAN 25 1923 19 ..... Burial Permit Clerk. Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1922 to Jan 25 1923, that I last saw her alive on Jan 24 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

(
Arteriosclerosis
Interstitial Nephritis
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Dyspepsia
(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell M. D.

Jan 25 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Jan. 29 1923

20 UNDERTAKER Margaret D. Flynn ADDRESS 14 S. Eutaw St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71599 D71599

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 107 Clayton St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin L. Cronin

(a) RESIDENCE. No. 107 Clayton St. Ward. 24

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 21 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Cronin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Alma Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Cronin (Address) 107 Clayton St

15 Filed JAN 25 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk:

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 17, 1923, to Jan 24 1923

that I last saw h[illegible] alive on Jan 24 1923

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. K. Campbell M. D.

Jan 26, 1923 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loly Cross A. A. Co.	Jan 25 1923

20 UNDERTAKER Margaret V. Hynes ADDRESS 1422 Light St

D71600

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71600

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1118 Hollins St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irvin Hunt

(Residence in Baltimore: No. 1118 Hollins St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. June (Month) 22 (Day) 1876 (Year)

7-AGE.	If LESS than 1 day,
46 yrs. 6 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country). North Carolina

PARENTS.

10-NAME OF FATHER. Joseph Lankford

11-BIRTHPLACE OF FATHER, (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER. Sarah Bennett

13-BIRTHPLACE OF MOTHER, (State or Country). North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur J. Hunt

(Address) 1118 Hollins St

15- JAN 25 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 24 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to their death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Henson M. D. (Coroner.)

Jan 25 1923 (Address) 701 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	Jan 26 1923
20-UNDERTAKER.	ADDRESS
George Smith	1532 Hollins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D71601

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71601

CERTIFICATE OF DEATH.

129

REGISTERED NO. C.....

1-PLACE OF DEATH Home for the Aged

CITY OF BALTIMORE: (No. 400 N. Fulton Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Griffin

(Residence in Baltimore: No. Home for the Aged of the M. E. Church St.; 45 yrs., ✓ mos. ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Apr. (Month) 11 (Day), 1841 (Year)

7-AGE, 81 yrs. 9 mos. 13 ds.

If LESS than 1 day, ...hrs. or ✓ ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Calvert County Md.

PARENTS.

10-NAME OF FATHER, Zachariah Howes.

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co. Md.

12-MAIDEN NAME OF MOTHER Mary Gibson

13-BIRTHPLACE OF MOTHER (State or Country). Calvert Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Hensley

(Address) 400 N. Fulton Ave

15- Robert P. Harrison, ..., 191.....
Burial Permit Clerk, Registrar.

JAN 25 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jany (Month) 24 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 19 1923, to Jany 24 1923, that I saw h[illegible] alive on Jany 23 1923, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

.....
Bronchitis Acute
..... (Duration) ✓ yrs. ✓ mos. 5 ds.

CONTRIBUTORY (Secondary) Nephritis Chronic
..... (Duration) 2 yrs. ✓ mos. ✓ ds.

(Signed) George C. Shannon M. D.

1/25, 1923 (Address) 400 Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem. DATE OF BURIAL, Jan 26, 1923

20-UNDERTAKER George J. Smith ADDRESS 1334 Harlem

N. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

160938
D71602

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71602

CERTIFICATE OF DEATH.

X 49

1-PLACE OF DEATH JOHNS HOPKINS HOSPIT.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME William Michael

(a) RESIDENCE NO. Fairmont W Va RR #6 ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 13 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Mrs. Augusta Michael

6 DATE OF BIRTH (month, day, and year) Dec 14 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Felix Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Cecelia Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant (Address) JOHNS HOPKINS HOSPIT.

15 Filed JAN 25 1923, 19 Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1923, to Jan 25, 1923, that I last saw him alive on Jan 25, 1923, and that death occurred, on the date stated above, at 3.9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder
Cystitis & pyelonephritis
Uremia

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Charles J Bidgood, M. D.

1/25, 1923 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmont W. Va

DATE OF BURIAL 1/25 1923

20 UNDERTAKER Joel Lewis 1439

ADDRESS E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 25 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71603

D71603

CERTIFICATE OF DEATH.

49

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1632 Norwood Ave ST., 8 WARD)

2-FULL NAME James A. Jones Sr

(a) RESIDENCE No. 1632 Norwood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lennie A. Jones

6 DATE OF BIRTH (month, day, and year): May 15th 1861

7 AGE: 61 Years 8 Months 10 Days. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Packer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Michelson 816

9 BIRTHPLACE (city or town) (State or country): Halifax Co Virginia

PARENTS

10 NAME OF FATHER: William Henbil Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Sarah Ann Woodall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Halifax Co Virginia

14 Informant: Lennie Jones

(Address): 1632 Norwood Ave

15 Filed: Robert P. Harrison, Registrar

Burial Permit Clerk.

JAN 25 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 25 1923

17

I HEREBY CERTIFY, That I attended deceased from June, 1922, to January 25, 1923, that I last saw him alive on January 22, 1923 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Neck +
Suffocation due to growth on neck

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary): Sarcoma

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? 1632 Norwood

Did an operation precede death? yes Date of June 1922

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Microscopical

(Signed) H. J. Carman, M. D.

25, 1923 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Jan 27th 1923

20 UNDERTAKER: Wm. Cook.

ADDRESS: North and Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(See affadirit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71604 S. **CERTIFICATE OF DEATH.** 90 D71604

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 804 Decker Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Godfred Hahn

(Residence in Baltimore: No. 804 Decker Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Wh

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Apr 19, 1861 (Month) (Day) (Year) 1856

7-AGE: 66 yrs. 9 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): (40)

9-BIRTHPLACE (State or Country): Balto

PARENTS.

10-NAME OF FATHER: Casper Hahn

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Amanda Pfeifer

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hahn

(Address) 804 Decker

15-

Filed Jan 25 1923 Robert J. Harrison Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 24, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Contributory (Secondary) Arterio Sclerosis

(Duration) yrs. mos. ds.

(Duration) mos. ds.

(Signed) Geo Clinton Blake M. D.
(Coroner.)

Jan 26 1923 (Address) 143 E. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Sacred Heart

DATE OF BURIAL, Jan 27, 1923

20-UNDERTAKER: Wm Cooke

ADDRESS 602 E Lexington

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Baltimore January 26' 1923

This is to certify that I, the undersigned, am a sister of Godfried Hahn, deceased, and know that said Godfried Hahn was born on the 19th day of April 1861.

Mrs Margaret Erchhart
2542 Fleet St.

Subscribed and sworn to before me this 26th day of January 1923.

Harry M. Rever
Notary Public

Spec.—1-10-21—M&T—1500 Blks.

D71605

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71605

CERTIFICATE OF DEATH.

51

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE. (No.) near Bucks Lane ST., ... WARD)

2-FULL NAME Fayette C. Coard Jr

(a) RESIDENCE NO. Bucks Lane ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	17	5	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) B. P. J.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Fayette C. Coard

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Emma Schwartz

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Fayette C. Coard Jr
(Address) Bucks Lane

15 Filed ....., 19 ..... Registrar
Robert P. Harrison,
Burial Permit Clerk.

N 25 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 24 19 23

17
I HEREBY CERTIFY, That I attended deceased from Jany 7 , 1923 , to Jany 24 , 1923 .
that I last saw h alive on Jany 24 , 1923 ,
and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Inflammatory Rheumatism
(duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Name
(Signed) Robt A. Hardesty M. D.
, 19 (Address) 911 E. Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Jan 26 1923
20 UNDERTAKER Wm J Pickrell & Sons	ADDRESS Montebello

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BATH MENT RECORD. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71606

D71606

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 349 Furrow ST., W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Strumsky

(a) RESIDENCE NO. 349 Furrow ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Strumsky

6 DATE OF BIRTH (month, day, and year) May 5-

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
757	75	7	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) 440

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Strumsky

(Address) 349 Furrow St

15 Filed JAN 25 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 24, 1923.

that I last saw him alive on Jan 24, 1923,

and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Senility

Endocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert C Patrick, M. D.

1/27 1923 (Address) 2157 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Jan 27 1924

20 UNDERTAKER MR. & MRS. N. S. FINK, FUNERAL DIRECTORS 1835 W. PRATT ST.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71607

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71607

CERTIFICATE OF DEATH. X 91-002

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 406 S Smallwood ST. 20 WARD)

2-FULL NAME John Funk

(a) RESIDENCE NO. Ann Arundel Co. ST., Annapolis WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 1 mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 15 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Michal Funk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Cunigunda Selig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Dittmann
(Address) 406 S Smallwood St

15 Filed Robert F. Harrison, Registrar
Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 25 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23 , 1923 , to Jan 24 , 1923 , that I last saw h— alive on Jan 23rd , 1923 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Trauma

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis.
(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard L. Israel, M. D.

1/24, 1923 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL Jan 26 1923

20 UNDERTAKER MR. & MRS. N. S. FINK, FUNERAL DIRECTORS 1638 W. PRATT STREET — ADDRESS

McCAULEY ✓

Spec.—1-10-21—M&T—1500 Bks.

161104
D71608

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71608

CERTIFICATE OF DEATH.

100-00

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (NO. ..... ST., 13 WARD)

2-FULL NAME Herbert F. McCauley

(a) RESIDENCE No 1324 Edmondwood Ave., Hampden ST., 13 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 14 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Herbert F. McCauley

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ethel Bowerson

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed JAN 25 1923, 19 ..... Registrar Robert F. Harrison

Dated Permit Mailed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1923, to January 24, 1923, that I last saw him alive on January 24, 1923, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Maria (Govans) — DATE OF BURIAL Jan 26 1923

20 UNDERTAKER Horace H. Burgee — ADDRESS 3631 Falls Rd.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71609

CERTIFICATE OF DEATH.

74-001

D71609

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Plaza Apts Park Ave & Mulberry ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia Williams

(a) RESIDENCE NO. Plaza Apts. Park Ave & Mulberry WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Abraham Williams

6 DATE OF BIRTH (month, day, and year): May 15-1867

7 AGE: Years 56 Months 8 Days 8 If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: George Gillus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sophia Oliver

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Abraham Williams

(Address) Plaza Apts. Park Ave. + Wilson St.

15 Filed Jan 25 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23 1923 to Jan 24 1923.

that I last saw her alive on Jan 23 1923,

and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 0 yrs. 0 mos 1 ds.

CONTRIBUTORY (Secondary): none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Physical Examination

(Signed) R B Tennyson, M. D.

Jan. 25, 1923 (Address) 617 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Jan 26 1923

20 UNDERTAKER: Jno M. Johnson — ADDRESS 1234 Etting St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71610

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71610

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 330 Wyman Ave. St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar White Bledsoe

(Residence in Baltimore: No. 330 Wyman Ave. St.; yrs. Adv. 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. February 24th, 1..87
(Month) (Day) (Year)

7-AGE. 52 yrs. 11 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk, Calvert St...
(b) General nature of industry, business, or establishment in which employed (or employer) Penn. R. R. Co.

9-BIRTHPLACE, (State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, E. R. Bledsoe

11-BIRTHPLACE OF FATHER, (State or Country). Va.

12-MAIDEN NAME OF MOTHER, Sally ?

13-BIRTHPLACE OF MOTHER, (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Bledsoe

(Address) 330 Wyman Ave.

15- [illegible] 192...

Robert P. Harrison,
Burial Permit Clerk. Registrar.

N 251323

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 24th, 192.3
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D.
(Coroner.)

Jan. 24th, 192.3 (Address) 1632 Belnord Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cem.	Jan. 26, 1923

20-UNDERTAKER.	ADDRESS.
Joseph B. Cook	1003 N. Balto.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71611

D71611

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 Hollins ST.: 18 WARD)

2-FULL NAME Orlando Allen

(a) RESIDENCE. NO. 1218 Hollins ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Mrs. Sophronia Allen

6 DATE OF BIRTH (month, day, and year) Jan 5 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	—	20	

8 OCCUPATION OF DECEASED Retired clerk

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing store

(c) Name of employer —

009

9 BIRTHPLACE (city or town) (State or country) N. J. State

PARENTS

10 NAME OF FATHER Hiram Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J. State

12 MAIDEN NAME OF MOTHER Mary Morse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J. State

14 Informant Mrs. Sophronia Allen
(Address) 1218 Hollins St.

15. Filed JAN 25 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1923, to Jan 24, 1923, that I last saw him alive on Jan 24, 1923, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. L. McCardell, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem. DATE OF BURIAL: Jan 26 1923.

20 UNDERTAKER: John O. Mitchell ADDRESS: 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 25 1923

(Katherine A. Martin)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71612

CERTIFICATE OF DEATH.

90 D71612

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2323 Linden Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Katherine A. Martin

(Residence in Baltimore: No. 2323 Linden Ave

life St., yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX. Female

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Widow

6 DATE OF BIRTH ....., 1863
(Month) (Day) (Year)

7 AGE 60 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or Country) Baltimore Md

PARENTS.

10 NAME OF FATHER Noah Cullison

11 BIRTHPLACE OF FATHER (State or Country) Balto Md

12 MAIDEN NAME OF MOTHER Alexine Turner

13 BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14 I HEREBY CERTIFY, THAT I ATTENDED DECEASED FROM ..... 19.., TO ..... 19.., AND LAST SAW HIM ALIVE ON ..... 19.., AND THAT DEATH OCCURRED ON THE HOUR AND DATE STATED ABOVE. THE CAUSE OF DEATH WAS AS STATED BELOW, TO THE BEST OF MY KNOWLEDGE AND BELIEF.

(Informant) L. Turner Bassman

(Address) 2323 Linden Ave

15

Filed ..... Registrar.

Robert. Bo Harrison,
Burial Permit Clerk.

JAN 25 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH June 23, 1922
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest (or autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Shipley Thomas M. D.
(Coroner)

June 24, 1922 (Address) 362 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL London Park Cem DATE OF BURIAL Jan 27, 1923

20 UNDERTAKER John O Mitchell ADDRESS 1201 W Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D71613

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71613

122-001

CERTIFICATE OF DEATH

1-PLACE OF DEATH Born Lecones Hospital Guilford.

CITY OF BALTIMORE: (No. 32 Whitefield Rd ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Roberts Jr

(a) RESIDENCE No. 32 Whitefield Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Last	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Westminster
(State or country) Maryland

PARENTS

10 NAME OF FATHER C. B. Roberts

11 BIRTHPLACE OF FATHER (city or town) Westminster
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Whyte Cross

13 BIRTHPLACE OF MOTHER (city or town) Westminster
(State or country) Maryland

14 Informant J. S. Roberts
(Address) Reisterstown Md.

15 Filed JAN 25 1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1923, to Jan 25, 1923, that I last saw ~~him~~ alive on Jan 25, 1923, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

acute right heart failure, cholemia

Ruptured oesophageal varix

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) hypertrophic cirrhosis of liver (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~Not stated~~ at home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) C. Sutherland, M. D.

Jan 25 1923 (Address) Bon Secours Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Jan 27 1923.

20 UNDERTAKER Henry Jenkins Son & Co ADDRESS Druid Hill & Laurens

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Alcoholic

(Bubb) ✓

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71614 D71614

CERTIFICATE OF DEATH. X 124

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin T. Hospital ST., 19 WARD)

2-FULL NAME Mrs. Mary Helen Bubb.

(a) RESIDENCE NO..... Whitehall, md ST., ... WARD White Hall Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of P Lewis Bubb

6 DATE OF BIRTH (month, day, and year) Sept 15, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Shaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Ella Bashon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant P Lewis Bubb
(Address) White Hall. Md.

15 Filed JAN 25 1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24-1923

17 I HEREBY CERTIFY, That I attended deceased from 1-23-, 1923, to 1-24-, 1923,

that I last saw her alive on 1-24-, 1923

and that death occurred, on the date stated above, at 7.50 a m.

The CAUSE OF DEATH* was as follows:

Empyema, Full duration
Pleurisy, days.

(duration) ..... yrs. ..... mos 15 ds.

CONTRIBUTORY (Secondary) Genus epidemica

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 1-20-23

Was there an autopsy? Yes

What test confirmed diagnosis? Symptoms

(Signed) E. Newton Le Compte, M. D.

1-24, 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Grove, Parkton — DATE OF BURIAL Jan 26, 1923

20 UNDERTAKER E. LeRoy Stiffler — ADDRESS 125 E North Ave,

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71615

CERTIFICATE OF DEATH.

100-001

D71615

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home & Infirmary

2-FULL NAME Miss Sophia Orrick

(a) RESIDENCE NO. 142 W. Lanvale ST., City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White American	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) April 4th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None.

9 BIRTHPLACE (city or town) Berkley Springs (State or country) Morgan County, W. Va

PARENTS

10 NAME OF FATHER Johnson Orrick

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER Margaret A Cooker

13 BIRTHPLACE OF MOTHER (city or town) Shepherdstown (State or country) Jefferson Co. Virginia

14 Informant H. A. Orrick

(Address) Garrett Bldg Baltimore

15 FILED JAN 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 12 1923 to Jan 24 1923.

that I last saw her alive on Jan 24 1923,

and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis & Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Physical findings

(Signed) George P. Conner, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Jan 26 1923.

20 UNDERTAKER Henry Mankins & Son Co — ADDRESS Eutaw & Lanvale Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161136 D71616 23 D71616

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevieve Kaliszak

(a) RESIDENCE NO 1908 Aliceann St City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE BLANKS MUST BE FILLED IN FOR EVERY DEATH. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1, 1917

7 AGE — Years: 5 — Months: 11 — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jende Kaliszak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 JAN 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1923, to January 25, 1923, that I last saw her alive on January 25, 1923, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Encephalitis, Epidemic

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary — DATE OF BURIAL Jan 27 1923

20 UNDERTAKER John M Weber — ADDRESS 1803 Bank

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71617

CERTIFICATE OF DEATH.

181-09 D71617

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 636 W. Lombard St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Chas Enright

(Residence in Baltimore: No. 636 W. Lombard St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-Single, Married, Widowed or Divorced, (Write the word.) Widower

6-DATE OF BIRTH. Oct (Month) 19 (Day) 1872 (Year)

7-AGE. 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. machinist
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto city

PARENTS.

10-NAME OF FATHER. C. Enright

11-BIRTHPLACE OF FATHER, (State or Country). Balto

12-MAIDEN NAME OF MOTHER. M. Culloch

13-BIRTHPLACE OF MOTHER, (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Enright

(Address) 1232 Ashland

15-JAN 26 1923 Filed 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 24 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ Inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or~~ Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Inhalation

(Duration) ~~yrs.~~ a few hrs mos. ds.

CONTRIBUTORY (Secondary) bad ventilation Gas fixtures

(Duration) yrs. mos. ds.

(Signed) H K Gorman M. D. (Coroner.)

1-26 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery DATE OF BURIAL, Jan 27, 1923

20-UNDERTAKER. George J Ruth ADDRESS 1735 Hanford Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71618

CERTIFICATE OF DEATH. X 101-001

D71618

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 11 WARD)

2-FULL NAME Elmira Shipley

(a) RESIDENCE NO. Oakland Md ST., WARD Oakland Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Shipley

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 63; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Howard Co. Md.

PARENTS

10 NAME OF FATHER: John Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Eliza Benson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ellis Shipley

(Address): Sykesville Md

15 FILED JAN 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1923, to January 26, 1923, that I last saw her alive on January 26, 1923, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis

Cholelithiasis

unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Lobar pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James Hubert Wilkerson, M. D.

19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Md — DATE OF BURIAL: Jan 29 1923

20 UNDERTAKER: Jas. R. Heer — ADDRESS: Sykesville

Spec.—5-19-13—M. & T.—500 Bks.

Wladyslaw Lewandowski

D71619

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D71619

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (NO. 1413 Aisquith ST.; 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wladyslaw Lewandowski

(Residence in Baltimore: No. 1413 Aisquith St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, December 16, 1922
(Month) (Day) (Year)

7-AGE, 0 yrs. 2 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Stanislaw Lewandowski

11-BIRTHPLACE OF FATHER (State or Country), Russian Poland

12-MAIDEN NAME OF MOTHER, Antonia Andrzejewski

13-BIRTHPLACE OF MOTHER (State or Country), Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanislaw Lewandowski

(Address) 1413 Aisquith St.

15- Filed JAN 26 1923 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 25, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 22 1923, to Jan 25 1923, that I saw h alive on Jan 24 1923, and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:

1. Pyo-meningitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. 1 ds.

(Signed) [illegible] M. D.

Jan 25, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, Jan 26, 1923

UNDERTAKER Wm Falkowski — ADDRESS Eastern Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71620

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D71620

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2572 Madison av ST., 13 WARD)

2-FULL NAME Eva Quitt

(a) RESIDENCE NO. 2572 Madison av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leon Quitt

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sara unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Jack Leurs

(Address) 1439 Eutaw st

15 Filed JAN 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 *, 1923, to Jan 25, 1923, that I last saw h Sr alive on Jan 25, 1923, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Endocarditis.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Joseph A. Jeffries, M. D.

Jan 26 1923 (Address) 1516 Madison av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bals Hebrew Cem	1/26 1923
UNDERTAKER	ADDRESS
Jack Leurs	1439 Eutaw st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS DATA IS USED FOR STATISTICAL PURPOSES ONLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Pettie's

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71621

D71621

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 Wvelcome al ST.: 77 WARD)

2-FULL NAME Robert Pettie

(a) RESIDENCE. NO. 116 Welcome al ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
m	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Morgan Pettie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lily Eyres

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Dorothy Eyres

(Address) 116 W Welcome al

15 Filed . 19 ROBERT R. KRAUTER, Registrar

JAN 26 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/23/ 1923, to 1/25/ 1923,

that I last saw him alive on 1/25/ 1923,

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute recurrent Bronchitis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Guy Bowley, M. D.

1/26/ 1923 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Humicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	1/29/ 1923
20 UNDERTAKER	ADDRESS
Wm Lattimore & Bro	

NOTICE.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71622

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D71622

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1446 N. Monroe St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Fannie Paige

(Residence in Baltimore: No. 1446 N. Monroe St. St., 18 yrs..... mos..... ds.)

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced (Write the word.): Widow

6-DATE OF BIRTH: about (Month) (Day) 87 (Year)

7-AGE: 52 yrs..... mos..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of Industry, business, or establishment in which employed (or employer): 041

9-BIRTHPLACE (State or Country): Va.

PARENTS.

10-NAME OF FATHER: Kit Cooper

11-BIRTHPLACE OF FATHER, (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Rose Roy

13-BIRTHPLACE OF MOTHER, (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. R. Newman

(Address) 1338 N. St. N.W.

15- Filed JAN 26 1923 192

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 23 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Jan. 25 1923 (Address) 2802 E. Lanvale

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn. DATE OF BURIAL, Jan. 26 1923

20-UNDERTAKER, James F. Dennis ADDRESS, 203 Preston St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71623

D71623

CERTIFICATE OF DEATH.

10

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 S. Woodyear ST., 14 WARD)

2-FULL NAME Lorena Carey

(a) RESIDENCE NO. 312 S. Woodyear ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE BLANKS MUST BE FILLED IN COMPLETELY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 26 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	11			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Thos Carey

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Nona Hartzell

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Nona Carey
(Address) 312 S. Woodyear

15 Filed JAN 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/24/23 19

17 I HEREBY CERTIFY, That I attended deceased from 1/24/23, 19 . to 1/24/23, 19 ,

that I last saw h— alive on 1/24/23, 19 ,

and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) one day yrs. mos 4 ds.

CONTRIBUTORY
(Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Unknown Date of 1-0-23

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Kelly, M. D.

1-26, 19 23 (Address) 1200 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Jan 27 1923

20 UNDERTAKER John J. Fields — ADDRESS 1200 W. Lombard

D71624

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D71624

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. in door way 710 W Balto St. St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius Hauck

(Residence in Baltimore: No. 222 S Norris St.; yrs....mos....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6-DATE OF BIRTH: Dont Know (Month) (Day) (Year)

7-AGE: 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer): 040

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: John Hauck

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Reichard

(Address) 222 S Norris St

15- Filed JAN 26 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 24 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~autopsy or inquiry.~~ (Inquest, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart

(Duration) yrs. Dont Know mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) W. K. Jamison M. D.
(Coroner.)

1-25 1923 (Address) 417 W Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Balto Cemeteries — DATE OF BURIAL: Jan 29, 1923

20-UNDERTAKER: John J Fields — ADDRESS: 1200 W Lombard

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

99-002

D71625

D71625

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 N Castle ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Fisher

(a) RESIDENCE NO. 521 N Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anthony Fisher

6 DATE OF BIRTH (month, day, and year): Aug 20-1850

7 AGE: Years 72 Months 5 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Geo Quinn (Address) 521 N Castle St

15 JAN 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1- 1922 to Jan 24 1923

that I last saw her alive on Jan 20 1923

and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Senile Bronchitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical Course

(Signed) Geo Edelson Bladed, M. D.

Jan 25 1923 (Address) 1436 Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem — DATE OF BURIAL: Jan 26 1923

20 UNDERTAKER: John Sullivan — ADDRESS: 1008 Orleans

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71626 144 D71626

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1137 Scott ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Loretta Durall

(a) RESIDENCE No. 1137 Scott ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Warner Durall

6 DATE OF BIRTH (month, day, and year): Aug. 9. 1900

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
22	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home duties

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Robt Duckett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: McHale

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs Kathy Duckett

(Address): 1137 Scott St

15 JAN 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19. 1923 to Jan 24. 1923.

that I last saw h alive on Jan. 24. 1923

and that death occurred, on the date stated above, at 12 20 p m.

The CAUSE OF DEATH* was as follows:

Post Partum Haemorrhage

(duration) ..... yrs. 1 mos 1 ds.

CONTRIBUTORY (Secondary) Confinement

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Mb Fuhlinger M. D.

1/25 1923 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery

DATE OF BURIAL: Jan 27 1923

20 UNDERTAKER: James Degnan & Son

ADDRESS: 1000 S. Pacas St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71627

CERTIFICATE OF DEATH.

161-001

D71627

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1137 Scott St ST., 21 WARD)

2-FULL NAME James Jerome Durall

(a) RESIDENCE NO. 1137 Scott St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 24/23

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Warner Durall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Duckett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Warner Durall (Address) 1137 Scott St

15 Filed JAN 26 1923 ROBERT H. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1923, to Jan 24, 1923, that I last saw alive on Jan 24, 1923 and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Congenital debility

(duration) 9 yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Engelmeyer M. D.

1/25, 1923 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters cemetery — DATE OF BURIAL: Jan 27 1923

20 UNDERTAKER: James Dignan & Son — ADDRESS: 1000 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D71628 — 90 — D71628

CERTIFICATE OF DEATH

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1902 W. Balto. St. St. 21 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip Lindemeyer

(Residence in Baltimore: No. 1902 W. Balto St St.: 35 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: Sept 13, 1858 (Month) (Day) (Year)

7-AGE: 64 yrs. 4 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Paper dealer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): New Brunswick

PARENTS

10-NAME OF FATHER: Philip Lindemeyer

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Anna Herbert

13-BIRTHPLACE OF MOTHER (State or country): N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herbert Lindemeyer.

(Address) 1929 Edmondson Ave.

15 Filed JAN 26 1923, 191 — ROBERT R. KRAUTER, Registrar

Burial Permit Granted

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Jan 25, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 —, 1922, to Jan 25 —, 1923, that I saw h[illegible] alive on Jan 25 —, 1923, and that death occurred on the date stated above, at 10.20 a.m.

The CAUSE OF DEATH* was as follows:

Chron Valvular Disease of Heart

Following a Stab wound of neck

(Duration) 41 yrs ago — yrs. mos. ds

Contributory (SECONDARY) Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

JAN 25 1923 (Address) 207-8-Professional Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Lorraine Cem

DATE OF BURIAL: Jan 27, 1923

20-UNDERTAKER: Joseph D. Cook

ADDRESS: 1003 N. Eutaw St

n of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
JSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION
mportant. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71629

CERTIFICATE OF DEATH.

15 181-005 D71629

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2805 Walbrook Ave St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence A. Berry.

(Residence in Baltimore: No. 2801 Windsor Ave St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Married

6-DATE OF BIRTH. Dec. 18, 1879
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
43 yrs. 1 mos. 6 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. merchant
(b) General nature of industry, business, or establishment in which employed (or employer). Sheet metal

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Alex. Berry.

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER, Elz. Shelton

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Hilda Berry

Address) 2801 Windsor Ave

JAN 26 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 24, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon monoxide poison. accidental. (automobile)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. O'Hennessy M. D.
(Coroner)

Jan. 26 1923 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
London Park Cemetery Jan 27 1923

20-UNDERTAKER, ADDRESS
Chas. G. Black 742 W. North ave

Spec.—1-10-21—M&T—1500 Bks.

D71630

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 D71630

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 7 WARD)

2-FULL NAME Capt. Mallory Read.

(a) RESIDENCE No. 3008 St. Phillip St., New Orleans, La, ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 18 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Alice Read (wife) +

6 DATE OF BIRTH (month, day, and year) Feb 22, 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	10	26.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pilot.

(b) General nature of industry, business, or establishment in which employed (or employer) (") 186

(c) Name of employer (")

9 BIRTHPLACE (city or town) (") (State or country) La.

PARENTS

10 NAME OF FATHER Charles W. Read. (")

11 BIRTHPLACE OF FATHER (city or town) Miss. (State or country)

12 MAIDEN NAME OF MOTHER Rova Hall. (")

13 BIRTHPLACE OF MOTHER (city or town) (") (State or country) Miss.

14 ~~Informant~~ (Address) Records. JOHNS HOPKINS ~~HOSPITAL~~

15 Filed JAN 26 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1923, to Jan 25, 1923, that I last saw him alive on Jan 25, 1923, and that death occurred, on the date stated above, at 9¼ A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the bladder

(duration) yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Louisiana

Did an operation precede death? yes Date of Jan 1 23

Was there an autopsy? yes

What test confirmed diagnosis? Cystoscopy

(Signed) Franklin P. Johnson, M. D.

, 19 (Address) John. Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Orleans DATE OF BURIAL Jan 26 1923

20 UNDERTAKER Jos. H. Tuttle ADDRESS 2700 Edmondson

D71631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C..... D71631

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp 23 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Kroch

(Residence in Baltimore: No. 1706 Monroe St.; yrs..... mos..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): ~~Married~~

6-DATE OF BIRTH: Jany (Month) 7 (Day) 1923 (Year)

7-AGE: ..... yrs. ..... mos. 11 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: John Kroch

11-BIRTHPLACE OF FATHER, (State or Country): —

12-MAIDEN NAME OF MOTHER: Books —

13-BIRTHPLACE OF MOTHER, (State or Country): —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hosp

(Address) .....

15- FILED JAN 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jany 18 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malformation Aorta & Pulmonary valves. (Autopsy at Hosp.)

(end of term)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Remains with - 7 months

gestation (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Mallon M. D. (Coroner.)

1-22 1923 (Address) 508 E Northern

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. ..... 19....

JOHNS HOPKINS HOSPITAL

20-UNDERTAKER, Commissioner Health, ADDRESS JAN 25 1923

ORIG. W. H. WOODALL

D71632 HEALTH DEPARTMENT—CITY OF BALTIMORE D71632

CERTIFICATE OF DEATH.

2 91-00

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 616 So. Washington St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ANTONI GARDOWSKI;

(Residence in Baltimore: No. 616 So. Washington St.; yrs. 13 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male,	White,	Married

6-DATE OF BIRTH. Unknown, ... 1..... (Month) (Day) (Year)

7-AGE. About 46 yrs. 0 mos. 0 ds. If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Day laborer,
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Poland,

PARENTS.

10-NAME OF FATHER. John Gardowski,

11-BIRTHPLACE OF FATHER, (State or Country). Poalnd,

12-MAIDEN NAME OF MOTHER. Unknown,

13-BIRTHPLACE OF MOTHER, (State or Country). Poland,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. F. Sadowski
for Wodislawa Gardowsky.
(Address) #616 S. Washington St.

15- Filed JAN 26 1923 19... ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 24 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquisition (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho Consolidation

(Duration) yrs. mos. ds.

(Signed) Geo Clinton Blades M. D.
(Coroner.)

Jan 26 1923 (Address) 143 E. Bway

*State the Disease Causing Death, or, In deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
ST. STANISLAUS CEM.	Jan. 27, 1923.
20-UNDERTAKER. M. F. Sadowski	ADDRESS 705 S. Ann St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Was alluded to by Superior

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

D71633 HEALTH DEPARTMENT—CITY OF BALTIMORE D71633

CERTIFICATE OF DEATH.

Registered No. C 114

1-PLACE OF DEATH

City of BALTIMORE: (No. 738 N. Eutaw St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. F. Zimmer

(Residence in Baltimore: No. 738 N. Eutaw St. St.; 52 yrs., 9 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): married

6-DATE OF BIRTH: March 30, 1870 (Month) (Day) (Year)

7-AGE: 52 yrs. 9 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Upholsterer
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Daniel Zimmer

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER:

13-BIRTHPLACE OF MOTHER, (State or Country):

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. F. Zimmer

(Address) 738 N. Eutaw St.

15-

Filed JAN 26 1923 ROBERT R. KRAUTER, Registrar. Per Mrs. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 24, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Gastro-enteritis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ac. Dilatation of Heart 5 min.

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner)

Jan. 25 1923 (Address) 2802 Eutaw Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park DATE OF BURIAL: Jan 27 1923

20-UNDERTAKER: Per Mrs. John W. Teufel & Son ADDRESS: 801 W. Fayette St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D71634

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST., 12 WARD) (If death occurred in hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Kennard

(a) RESIDENCE NO. 437 Bloom St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col.

5 If Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: Years 47; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butler

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer Dr. Chas. Mitchell

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Kennard

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Sally Kennard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant University Hospital Records (Address)

15 Filed JAN 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/23/1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1922, to Jan 23, 1923, that I last saw him alive on Jan 23, 1923, and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of (No)

Was there an autopsy? Yes

What test confirmed diagnosis? Suspicion

(Signed) Wallitka, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL 1/26/1923

20 UNDERTAKER Samuel Schenker ADDRESS 518 W Biddle

N. B.—WHITE PENCIL, WITH CARBON INK, THIS CERTIFICATE RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71635

CERTIFICATE OF DEATH.

90 D71635

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Aged of the M. E. St. Church WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James L. Smith.

(Residence in Baltimore: No. 400 St. Fulton Ave St. 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 26 (Month), (Day), 1836 (Year)

7-AGE, 86 yrs. 7 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, James L. Smith

11-BIRTHPLACE OF FATHER (State or Country), Del.

12-MAIDEN NAME OF MOTHER Emily Hall

13-BIRTHPLACE OF MOTHER (State or Country). Fredertown Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Cuddy

(Address) 400 N. Fulton Ave

15- Filed JAN 26 1923, 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jany (Month) 26 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 2 1923, to Jany 26 1923, that I saw h-im alive on Jany 25 1923, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 3 yrs. ✓ mos. ..... ds.

CONTRIBUTORY (Secondary) Valvular Heart trouble

(Duration) 2 yrs. ✓ mos. ..... ds.

(Signed) George L. Shannon M. D.

1/26, 191... (Address) George L. Shannon 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Jan 27..., 1923

20-UNDERTAKER Lenzi J Smith ADDRESS 1532 Hollins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71636

CERTIFICATE OF DEATH.

90 D71636

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH PEN AND INK—THIS IS A PERMANENT RECORD. Every question should be answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph R. Lewis

(a) RESIDENCE NO. 525 Falls Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records. (Address)

15 JAN 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 19 23

17 I HEREBY CERTIFY, That I attended deceased from December 18 19 22 to January 25 19 23.

that I last saw him alive on January 25 19 23.

and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McKee M. D.

1/26/19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Jan 27 1923
20 UNDERTAKER Horace F. Burgee	ADDRESS 363 Hollins

Spec.—1-10-21—M&T—1500 Bks. Katherine J. Powers ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71637

CERTIFICATE OF DEATH.

185 D71637

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Md General Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Powers

(a) RESIDENCE NO. 2726 Gorsuch Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 8 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Powers

6 DATE OF BIRTH (month, day, and year) May 24th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas. J. Franke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Christina Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant James F. Powers
(Address) 2726 Gorsuch Ave

15 Filed JAN 26 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25/23

17 I HEREBY CERTIFY, That I attended deceased from 1/10/23, 19..., to 1/25/23, 19..., that I last saw h-er alive on 1/25/23, 19..., and that death occurred, on the date stated above, at 11 45 a m.

The CAUSE OF DEATH* was as follows:

Duct Pabitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1/16/23

Was there an autopsy? Yes

What test confirmed diagnosis? Clynical findings

(Signed) Jno A Hopkins M. D.

, 19 (Address) 100 Gilsey Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cem	Jan 29 1923
20 UNDERTAKER	ADDRESS
E. Lehman & Son	1001 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA required should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Mary H (Minnie) Pritchard

D71638

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71638

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Dugeland ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary H Pritchard

(a) RESIDENCE No. 1716 Dugeland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 15-187

7 AGE Years 52 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Richard Pritchard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Jane A Higgins 1716 Dugeland St

JAN 26 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1923, to Jan. 25, 1923.

that I last saw her alive on Jan. 25, 1923

and that death occurred, on the date stated above, at 11.40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A H Cullen M. D.

1/26/23 (Address) 2707 W. Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery Baltimore City

DATE OF BURIAL January 29 1923

20 UNDERTAKER Geo P Johnson

ADDRESS 1422 W. Baltimore

18.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered and full information should be stated EXACTLY. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Bks.

D71639

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71639

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

2-FULL NAME James Cater

(a) RESIDENCE NO. 1121 Aisquith St. City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 4 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Roland Cator

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen Rooney

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 17 1923 to Jan 24 1923 that I last saw him alive on January 22 1923 and that death occurred, on the date stated above, at 11 20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) ..... yrs. ..... mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL Jan 28 1923

20 UNDERTAKER E. W. Conklin

ADDRESS 924 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

226

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71640

CERTIFICATE OF DEATH.

31 D71640

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 E. Lafayette Ave St., 9 WARD)

2-FULL NAME Margaret L. Kerns

(a) RESIDENCE NO. 1305 E. Lafayette Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James J. Kerns

6 DATE OF BIRTH (month, day, and year): Jan 29-1867

7 AGE: Years 55 Months 11 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary Kerns

(Address) 1305 E. Lafayette Ave

JAN 26 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 24th 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1923, to Jany 24, 1923, that I last saw h alive on Jany 24, 1923, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos 24 ds.

CONTRIBUTORY (Secondary) Toxaemia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum pos. Tb.

(Signed) George Asher Baldwin M. D.

1/24 1923 (Address) 1517 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 1/27 1923

20 UNDERTAKER: Chas E. Evans & Son

ADDRESS: 11 & W. Mt Royal Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71641 D71641

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1517 N. Gilmor (St.) 15 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lavinia V. Callahan

(a) RESIDENCE. NO. 1517 N. Gilmor ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Callahan

6 DATE OF BIRTH (month, day, and year) July 10-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Mary Employ Co

(c) Name of employer: Balto City

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Patrick Callahan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mary E. Watterson 1517 N. Gilmor St

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

N 26 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 16th, 1923, to Jan 24th, 1923, that I last saw h... alive on Jan 24th, 1923, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Enteritis

Simple ulceration Colitis (duration) — yrs. 7 mos. 28 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical & Clinical

(Signed) Wm J Sudler M. D.

1925, 1923 (Address) 1706 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Jan 27 1923

20 UNDERTAKER: Martin Fahey & Sons — ADDRESS: 1837 W North Ave

Cert 1 0303

PLACE OF DEATH D71642

11-001 V D. 71642

STATE OF MARYLAND
CERTIFICATE OF DEATH

D. 71642

County

Registration Dist. No. 16

Village or City Baltimore (No. 4014, Edmondson ave St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Residence, 4014 Edmondson Ave. In Baltimore 20 Years

2 FULL NAME Byrene Mackenzie Collie

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: May 31, 1884 (Month) (Day) (Year)

7 AGE: 38 yrs. 7 mos. 24 da. If LESS than 1 day hrs. or min. ?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Saleslady
(b) General nature of industry business, or establishment in which employed or (employer): Retail Department Store

9 BIRTHPLACE (State or country): Virginia

PARENTS

10 NAME OF FATHER: D. M. Collie

11 BIRTHPLACE OF FATHER (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Annie Lapham

13 BIRTHPLACE OF MOTHER (State or country): Virginia

I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss M. Clara Leach

(Address) 4014 Edmondson Ave

15 Robert F. Harrison, 192

Registrar

Burial Permit Clerk

N 26 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 25 (Day) 1923 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 17 1923, to Jan 25, 1923, that I last saw h[illegible] alive on Jan 25, 1923, and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH * was as follows:

Influenza

(Duration) yrs. mos. 7 da.

Contributory Secondary: Pleuritic Effusion

(Duration) yrs. mos. 2 da.

(Signed) Charles L Mayfield M.D.

Jan 26 1923 (Address) Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. da. In the State, yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 1/27/23, 19

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 Calvert St.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

CLANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; It should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 5 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

Not Tubercular

D71643

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71643

CERTIFICATE OF DEATH.

X-5-197

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE; (No. Mercy Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME La Rosa Ritubmi or Rindone

(Residence in Baltimore: No. 374 Forest St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1..... (Year)

7-AGE: 30 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Worker
(b) General nature of Industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Italy

PARENTS:

10-NAME OF FATHER, Antonio Larosa

11-BIRTHPLACE OF FATHER, (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Maria Pellegrini

13-BIRTHPLACE OF MOTHER, (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Coroners Office

(Address) Monument St.

15- Robert P. Harrison, 192.....

Burial Permit Clerk. Registrar.

JAN 26 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 25 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) which will be held Jan 29 1923 thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet wound of abdomen

Shot by person unknown

Suffered about 3 days

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) about 3 days

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Bruce Wilson (Coroner.) M. D.

192.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. 1 mos. 1 day ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Washington D.C.

19-PLACE OF BURIAL OR REMOVAL. Washington D.C. DATE OF BURIAL. Jan 26 1923

20-UNDERTAKER Robert Brooks & Son ADDRESS Calhoun & Fallen

B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71644

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71644

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2530 E. Madison ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Marie Williams

(a) RESIDENCE NO. 2530 E. Madison ST., 7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Fred Williams

6 DATE OF BIRTH (month, day, and year) June 9th 1831

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	91	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Klon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Andrew J. Poteet

(Address) 2530 E. Madison St.

15 Filed ....., 19 .....

Registrar

Robert F. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 19 22, to Jan 24, 19 23.

that I last saw h alive on Jan 23, 19 23

and that death occurred, on the date stated above, at 8/45 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 5 yrs. mos.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms

(Signed) F. Fred Rupprecht, M. D.

1923 (Address) 800 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. John's Cem. Rockhall — DATE OF BURIAL: Jan 27 1923

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 4032 Wolfe St

JAN 26 1923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71645

CERTIFICATE OF DEATH.

179 D71645

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 733 W. Fayette St., 4 WARD)

2-FULL NAME George M. Hoover

(a) RESIDENCE NO. 733 W. Fayette St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 1842

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
70	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Railroad man

(b) General nature of industry, business, or establishment in which employed (or employer): 0 17

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER George M. Hoover

11 BIRTHPLACE OF FATHER (city or town) Wash (State or country) D.C.

12 MAIDEN NAME OF MOTHER Selena Hunter

13 BIRTHPLACE OF MOTHER (city or town) Wash (State or country) D.C.

14 Informant Mrs. B. Hoover

(Address) 915 Light St. Apt. 2

15 Filed Jan 26 1923 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 20 1923 to Jan 26 1923, that I last saw him alive on Jan 26 1923 and that death occurred, on the date stated above, at 2 45 p m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Chronic Interstitial Nephritis

Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Hossmer, M. D.

1/26, 1923 (Address) 267 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Creek Cemetery Wash. D.C.

DATE OF BURIAL: Jan 27 1923

20 UNDERTAKER: George J. Smith

ADDRESS: 1000 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 26 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71646

CERTIFICATE OF DEATH.

52

D71646

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 427 E. Fitting ST., 24 WARD)

2-FULL NAME Helen R. Neill

(a) RESIDENCE NO. 427 E. Fitting ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): April 16, 1914

7 AGE: Years — Months: 9 — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Bahlman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: James Neill
(Address): 427 E Fitting St

15 Filed 1-26 1923 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/26 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/26/22, 19..., to Jan 26, 1923.

that I last saw h alive on Jan 26, 1923,

and that death occurred, on the date stated above, at 6:45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary): Contusion of Right Shoulder (Cause)

(duration) yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) ..... M. D.

Jan 26, 1923 (Address) 1101 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem

DATE OF BURIAL: 1-27-1923

20 UNDERTAKER: E. B. Hartz

ADDRESS: 115 E. Mt St

Burial Permit Clerk.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1926 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71647

CERTIFICATE OF DEATH.

D71647

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 Dukeland St. WARD 15)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence A. Edwards

(a) RESIDENCE NO. 1807 Dukeland WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 If Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis A. Edwards

6 DATE OF BIRTH (month, day, and year) March 9 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER George Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER L. Hungerford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Wm Wrightson

(Address) 1807 Dukeland

15 Filed JAN 26 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1923, to Jan 24, 1923

that I last saw he/she alive on Jan 24, 1923

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Sarcoma

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin Murray, M. D.

(Address) 1231 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Namby

DATE OF BURIAL 1/27 1923

20 UNDERTAKER W. F. Cook

ADDRESS 1201 E Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Any item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No alcoholic

Spec.—6-9-19—H. P. Co.—1000 Blks.

D71648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71648

CERTIFICATE OF DEATH.

1729

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward McGee

(a) RESIDENCE. No. 417 W. 23rd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? ? 1890

7 AGE 33 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edw. B. McGee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret McGee (Address) 417 W 23rd 1923

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

AN 26 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 9, 1923, to Jan. 25, 1923, that I last saw him alive on Jan. 25, 1923, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia following uraemic Cond

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic parenchymatous nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Krager, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery — DATE OF BURIAL: 1/29 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Monument

INSTRUCTIONS: Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71649

X101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 27 WARD)

2-FULL NAME Mrs. Blaine Rogers

(a) RESIDENCE No. Happy Hills Mt. Washington Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Practical Nursing

(b) General nature of industry, business, or establishment in which employed (or employer) 048

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Solomon Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Amanda Bough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 26 1923 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1923, to Jan 24, 1923, that I last saw her alive on January, 1923, and that death occurred, on the date stated above, at 10.00 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Nr Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. R. Bugg, M. D.

1923 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkersburg W. Va	Jan 27 1923

20 UNDERTAKER Wm Cook ADDRESS 602 E Monument

N.B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE SHOULD BE FILLED OUT IN THE PRESENCE OF INFORMANT. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71650 100-001 D71650

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 Homestead ST., 10 WARD)

2-FULL NAME Joseph T Swann

(a) RESIDENCE NO. 910 Homestead ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Swann

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo W Swann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary C Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary E Swann
(Address) 910 Homestead St

15 Robert P. Harrison, 19 .....
Registrar
Burial Permit Clerk.

JN 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 18 1923 to Jan 25 1923

that I last saw h/me alive on Jan 24 1923

and that death occurred, on the date stated above, at 3 AM m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. ..... mos. 15 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M D Simmons M. D.

11-26-1923 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Harmon Cemetery Co. Md.	Jan 27 1923

20 UNDERTAKER Harry H. Witzke ADDRESS 1511 Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT RECORDED EXACTLY AS mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71651 D71651

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 Lemon St.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Smith.

(a) RESIDENCE. NO. 815 Lemon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of Industry, business, or establishment in which employed (or employer) 023

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John S Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Hulbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bridgeport Conn

14 Informant Mary Smith

(Address) 1380 N Carlton

15 Filed JAN 27 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 17 1923 to Jan 23 1923

that I last saw h~~im~~alive on Jan 23rd 1923

and that death occurred, on the date stated above, at 11.55 P.M.

The CAUSE OF DEATH* was as follows:

~~Chronic~~ Acute Endocarditis

(duration) - yrs 2 mos. - ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Clark M. D.

19 (Address) Jan 25 1313 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr. Kirkbride DATE OF BURIAL Jan 27 1923

20 UNDERTAKER James J. Dennis ADDRESS 1303 Madison

N 27 1923

8.—WHITE PAPER. WITH CARBON BACK.—THIS IS A PERMANENT RECORD. ENTRY IS ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71652

D71652

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 N. Chester St ST.; 6 WARD)

2-FULL NAME Regina Gombert

(a) RESIDENCE. NO. 422 N. Chester St ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Frank Gombert

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
82	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Schieck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER — Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant (Address) Frank Gombert 422 N. Chester St.

15 Robert P. Harrison, Registrar

JAN 27 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1922, to Jan 25, 1923, that I last saw h[illegible] alive on Jan 23, 1923, and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? —

(Signed) B. F. Herzog MD, M. D.

1/28, 1923 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: Jan 29 1923

20 UNDERTAKER: L. Sander Sons ADDRESS: 1710 Fleet

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Brooks)

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71653 ✓ D71653

31

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 W. Church St. 22 Ward)

2-FULL NAME Ellen Brooks

(a) RESIDENCE. No. 17 W Church St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, ~~Married~~, ~~Widowed~~, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 1894

7 AGE: Years 28; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Housework O'D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Clarence Holmes

(Address): 17 W Church St

15 Filed JAN 27 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/25/ 1923

17

I HEREBY CERTIFY, That I attended deceased from 1/12/ 1923, to 1/25/ 1923,

that I last saw h alive on 1/25/ 1923,

and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Acute Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) J. Jno Cowley, M. D.

1/26/ 1923 (Address) 908 Shoppe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn ct — DATE OF BURIAL: Jan 27 1923

20 UNDERTAKER: J. L. Brown & Son — ADDRESS: 1054 W Mount St

P. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71654

CERTIFICATE OF DEATH.

129 D71654

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 E Chase ST., 8 WARD)

2-FULL NAME Elizabeth Kellum

(a) RESIDENCE NO. 1732 E Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 8 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
88 81	3	23		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Kellum

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Hancock

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Wm F. R. Guy.
(Address) 1236 N Broadway

15 Robert P. Harrison, Registrar

JAN 27 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1923, to Jan 25, 1923, that I last saw h alive on Jan 25, 1923, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible] M.D.

(Address) 1102 Johns Hopkins Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bonnie Rest Cem

DATE OF BURIAL 1/29 1923

20 UNDERTAKER H. Heemann

ADDRESS 32 S Broad.

B.—WRITE PLAINLY, WITH UNFADING INK. THIS BLANK IS PRINTED ON BOTH SIDES. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71655

CERTIFICATE OF DEATH.

11-001 D71655

1-PLACE OF DEATH — Curtis Bay — REGISTERED NO.

CITY OF BALTIMORE: (No. 1609 Pennington Ave ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles T. Blockston

(a) RESIDENCE No. 1609 Pennington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 15 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Curtis Bay (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Wesley T. Blockston

11 BIRTHPLACE OF FATHER (city or town) Catonville (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Ignetida A Souchon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Bessie M Ballman (Address) Eden Hill Maryland Ave

15 Robert P. Harrison, Registrar

JAN 27 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1923, to Jan 26, 1923, that I last saw him alive on Jan 26, 1923, and that death occurred, on the date stated above, at 1 45 P m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? X

(Signed) Geo. B. Davis, M. D.

1/26, 1923 (Address) 211 Church St, Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Jan 27 1923

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

I. B.—WRITE PLAINLY, WITH INDELIBLE INK. THE BLANKS MUST BE FILLED EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

D71656 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D71656

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 E. Fort Ave St. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Catherine Garrett

(a) RESIDENCE No. 437 E. Fort Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	34	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H. Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rockville Md

12 MAIDEN NAME OF MOTHER Mary J. Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montgomery Co Maryland

14 Informant John H. Garrett

(Address) 437 E Fort Ave

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk

JN 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1923

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1922, to Jan 26 23, 19

that I last saw h alive on Jan 26 23, 19

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of -

Was there an autopsy? yes

What test confirmed diagnosis? Examination

(Signed) John B. Holt M. D.

Jan 27 1923 (Address) 1703 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockville Md (Visalute) DATE OF BURIAL Jan 29 1923

20 UNDERTAKER John F. Denny ADDRESS 715 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D71657

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71657

CERTIFICATE OF DEATH.

X 90

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 723 St Paul (St.) 10 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Affleck

(a) RESIDENCE (No.) 723 St Paul (St.) (Ward) Mass.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? 50 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline P. Affleck

6 DATE OF BIRTH (month, day, and year) Jan 23 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacture

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

045

9 BIRTHPLACE (City or town) (State or country) England

PARENTS

10 NAME OF FATHER John Affleck

11 BIRTHPLACE OF FATHER (City or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER E. Swinton

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Scotland

14 Informant Minnie N. Kutall

(Address) 277 B. Way Paterson N J.

15 Filed ....., 19 ..... Registrar

Robert P. Harrison,

Burial Permit Clerk.

JAN 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-25 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 22 -, 1923, to Jan. 25 -, 1923, that I last saw him alive on Jan 25 -, 1923 and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Arterial hypertension

Arteriosclerosis

Myocardial Insufficiency.

(duration) yrs. 7 (?) mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mass. and Florida.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical exams only

(Signed) Thomas P. Sprunt, M. D.

1/27, 1923 (Address) 1030 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holyoke Mass

DATE OF BURIAL 1/28 1923

20 UNDERTAKER Robert Brooks & Son

ADDRESS 17 S Calhoun St

Spec.—1-10-21—M&T—1500 Bks.

D71658

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-60 D71658

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 W Franklin ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie C. Pagano

(a) RESIDENCE NO. 416 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Jos. Pagano

6 DATE OF BIRTH (month, day, and year): Nov 11

7 AGE — Years: 43 — Months: 2 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

069

9 BIRTHPLACE (city or town) (State or country): Rochester, Co Ind

PARENTS

10 NAME OF FATHER: Thos Rhodes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Gargana

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md,

14 Informant: Mrs Geo. S. Bennett

(Address): Easton Va.

15 Filed JAN 27 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/27 1923

17

I HEREBY CERTIFY, That I attended deceased from Jany 23, 1923, to Jany 27, 1923,

that I last saw her alive on Jany 26, 1923,

and that death occurred, on the date stated above, at 5 A, m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Petterson, M. D.

, 19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rhodesdale Md — DATE OF BURIAL: 1/27 1923

20 UNDERTAKER: Philip Henny — ADDRESS 2016 Auburn

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71659

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71659

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 711 Penna. Ave. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Bibbs

(Residence in Baltimore: No. 711 Penna Ave. St.; yrs., 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	married

6-DATE OF BIRTH. about ....., 1874
(Month) (Day) (Year)

7-AGE. about 49 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... waiter
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 070

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, Hazel Bibbs

11-BIRTHPLACE OF FATHER, (State or Country), Va

12-MAIDEN NAME OF MOTHER, D K

13-BIRTHPLACE OF MOTHER, (State or Country) D K.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Carrie Bibbs

(Address) 711 Penna. ave,

15- Robert P. Harrison,

Filed ..... 192.....

Registrar.

JAN 27 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 24, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Jan 26 1923 (Address) 2807 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, Jan 31 1923

20-UNDERTAKER, Samuel Wesley Riddick ADDRESS 578

A.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71660 D71660

CERTIFICATE OF DEATH. X 101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 713 (Street) George (St.) 17 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Ball

(a) RESIDENCE. No. 713 (Street) George St., Ward Northumberland Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Four mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 3rd 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 21

(b) General nature of industry, business, or establishment in which employed (or employer) Private family

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Tyskus Va

PARENTS

10 NAME OF FATHER Walter Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Gaskins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Evelyn Edwards

(Address) 765 George St

15 Filed 1 27 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23 1923 to Jan 24 1923

that I last saw her alive on Jan 24 1923

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Double)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John R Carey, M. D.

, 19 (Address) 752 George St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tyskus Wtf. Northumberland Co. Va	1/28 1923
20 UNDERTAKER Samuel Hensley	ADDRESS Biddle

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71661 D71661

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 802 Woodley (St.) 16 (Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara E. Ash.

(a) RESIDENCE. No. 802 Woodley St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46.	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shirt maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 086

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Jacob. Ash.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Trorlie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Phillip B. Hammond

(Address) 802 Woodley St

15 Filed JAN 27 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1923, to Jan 26, 1923,

that I last saw her alive on Jan 26, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Homer C. Todd M. D.

1/27, 1923 (Address) 735 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Savage Md	Jan 28 1923

20 UNDERTAKER ADDRESS

John D Mitchell 1201 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should write

Spec.—1-10-21—M&T—1500 Blks.

D71662 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D71662

CERTIFICATE OF DEATH. 100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3725 E. Lombard ST., 76 WARD)

2-FULL NAME Ludwig L. Haffpa

(a) RESIDENCE NO. 3725 E. Lombard ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Haffpa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Francis Kacz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Frank Haffpa (Address) 37 E. Lombard St

15 JAN 27 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1923, to Jan 26, 1923, that I last saw him alive on Jan 25, 1923 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia Primary

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tudor M. D.

1/26, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Jan 27 1923
20 UNDERTAKER	ADDRESS
Stephen J. Trialkowski	1005 Hanover

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D71663

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.: 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Schley -

(a) RESIDENCE. No. — St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Jan. 24, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			Hours 30 Hrs.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER Samuel Schley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maude Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant

(Address)

Robert F. Harrison,

Registrar

Burial Permit Clerk.

JAN 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1923, to Jan 25, 1923, that I last saw h[illegible] alive on Jan 25 1923 and that death occurred, on the date stated above, at 1 45 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity (26 weeks)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Anthony V. Bucheus M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS
Commissioner Health.	JAN 27 192

(0.7.0)

Make CARBON COPY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71664

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71664

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 586 Oxford St. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Ford

(a) RESIDENCE No. 586 Oxford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mrs Lucy Ford

(Address) 1021 Myrtle ave

15 Filed . 19 Robert P. Harrison, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-25-1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1923 to Jan. 25, 1923.

that I last saw him alive on Jan. 25, 1923,

and that death occurred, on the date stated above, at 6-50 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Apoplexy Cerebral

(duration) yrs. mos. ds. 15

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. ds. 5

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H H White, M. D.

. 19 (Address) 1118 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 1-27-1923

20 UNDERTAKER Daniel Easton

ADDRESS 916 Ca ave

1-27-1923

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71665

CERTIFICATE OF DEATH. 36-005 D71665

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 20 WARD)

2-FULL NAME Clifton Saunders

(a) **RESIDENCE NO.** 15 Stockston St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	23	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machanic

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm. Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records.
(Address)

15 Filed JAN 27 1923, 19 ... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from December 26, 1922, to January 25, 1923.

that I last saw him alive on January 25, 1923,

and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows: Tuberculous sinuses in neck, tuberculous abscess on back, probable tuberculous peritonitis. ? (duration) ? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Not to my knowledge. (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs.

(Signed) Clyde Miller C. M. D.

1/26/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 1-29 1923

20 UNDERTAKER Daniel Easton — ADDRESS 846 Ea ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71666

CERTIFICATE OF DEATH.

100-00/D71666

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1204 Division Street ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Annie E. Stepney

(a) RESIDENCE. No. 1204 Division Street ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C.	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) In Private Family
(c) Name of employer Mrs. William Caulk

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Nellie Thompson
(Address) 1204 Division St.

15 JAN 27 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-25 19 23

17 I HEREBY CERTIFY, That I attended deceased from 1-22, 19 23, to 1-25, 19 23,
that I last saw her alive on 1-25, 19 23,
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) William A. Harris, M. D.
, 19 (Address) 1200 Penna. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	1-27 1923
20 UNDERTAKER Daniel Easton	ADDRESS 216 Pa ave

A. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71667 — CERTIFICATE OF DEATH. — 129 D71667

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2207 Eastern ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Nowak

(a) RESIDENCE. NO. 2207 Eastern ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Nowak

6 DATE OF BIRTH (month, day, and year) October 6 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engine statione

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balt & Ohio

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Nowak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Eva Nowak

(Address) Robert P Hamilton.

JAN 27 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 1923 to Jan 24 1923

that I last saw him alive on Jan 24 1923

and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. Steele M. D.

1/26 1923 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	January 26 1923

20 UNDERTAKER Waydell Piffel & Son

ADDRESS 378 Mn

...ATH—THIS IS A PERMANENT RECORD. Every item of information must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71668

CERTIFICATE OF DEATH.

101-001 D71668

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 957 Harford Ave ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dunphy.

(a) RESIDENCE NO. 1957 Harford Ave ST., 10 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? 37 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: Owen Bannatan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Catherine Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mr. John J. Nolan 957 Harford Ave

15 Filed Jan 27 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-19, 1923, to 1-26, 1923, that I last saw h alive on 1-26, 1923, and that death occurred, on the date stated above, at 2 40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. J. Bernard Wells, M. D.

1/29, 1923 (Address) 917 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery Dalton Road. DATE OF BURIAL: Jan 29 1923

20 UNDERTAKER: Henry Hoerth Son ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 27 1923

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71669 D71669

CERTIFICATE OF DEATH.

141

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Rosina Berger

(Residence in Baltimore: No. 921 N. Eden St.; 27 yrs., 10 mos. 8 ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 17, 1895 (Month) (Day) (Year)

7-AGE, 27 yrs. 10 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Waiter Work
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John T Roberts

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Barbara E Walters

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) St Thomas J Berger

(Address) 921 N. Eden St

15-

Filed....., 191.....

ROBERT F. MAYLAND,

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 25 (Day), 1913 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 19 1913, to Jan. 25 1913, that I saw her alive on Jan. 25 1913, and that death occurred, on the date stated above, at 11-30 a.m.

The CAUSE OF DEATH* was as follows:

Septicemia Terminal

Bronchopneumonia (Primary)

(Duration) ...yrs...mos. 8 ds.

CONTRIBUTORY (Secondary) Generalized peritonitis

(Duration) ...yrs...mos...ds.

(Signed) A. Fuller Lord M. D.

1/25/13 191... (Address) Hebrew Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery DATE OF BURIAL, Jan 29.., 1913

20-UNDERTAKER Henry Lutz ADDRESS 1203 N. Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71670 001 D71670

D71670

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 539 Robert St. 14 Ward) REGISTERED NO. 122

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Johnson

(a) RESIDENCE. No. 539 Robert St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Johnson

6 DATE OF BIRTH (month, day, and year) November 29. 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Cooper 040

(c) Name of employer Kershenmer

9 BIRTHPLACE (city or town) (State or country) Lancaster Co Va

PARENTS

10 NAME OF FATHER Jerry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina ~~Lancaster Co Va~~

12 MAIDEN NAME OF MOTHER Laura Cooper Jan 29, 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Co Va

14 Informant Bertha Johnson (Address) 539 Robert St.

15 Filed JAN 27 1923, 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1923, to Jan 24, 1923, that I last saw him alive on Jan 24, 1923, and that death occurred, on the date stated above, at 3 A.M. m.

The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Enlarged Prostate.

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wilbur H Wright, M. D.

Jan 29, 1923 (Address) 1209 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ind Auburn Cem	1-28 1923

20 UNDERTAKER George T. A. Gibson ADDRESS 573 Fairmont

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

71671 D71671

HEALTH DEPARTMENT—CITY OF BALTIMORE

71671 D71671

CERTIFICATE OF DEATH.

X 100-001

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1659 Thomas av ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva R Hamilton

(a) RESIDENCE NO. 1659 Thomas av ST., WARD Westminster Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amos Hamilton

6 DATE OF BIRTH (month, day, and year) Feb 11 54

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	68	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work.

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Grapate Md.

PARENTS

10 NAME OF FATHER John Elder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Selby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Mary Hamilton
(Address) 1659 Thomas ave

15 Filed JAN 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1923, to Jan. 23, 1923, that I last saw her alive on Jan. 24, 1923, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Suspected

(Signed) J. E. Burnback M. D.

1-26 1923 (Address) 1531 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md — DATE OF BURIAL Jan 28 1923

20 UNDERTAKER W. M. Routson — ADDRESS 2238 N Mtd

Spec.—1-10-21—M&T—1500 Bks.

71672 HEALTH DEPARTMENT—CITY OF BALTIMORE 71672

D71672 CERTIFICATE OF DEATH. X 73 D71672

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital St. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME— William D. Kendall.

(a) RESIDENCE NO. Belton — ST., WARD Texas.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with unfading ink. This certificate is required by law. Every item should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~or WIFE of~~ Florence Kendall

6 DATE OF BIRTH (month, day, and year) July 3, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister 118

(b) General nature of industry, business, or establishment in which employed (or employer) Baptist Church

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky.

PARENTS

10 NAME OF FATHER— John G. Kendall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Miss

12 MAIDEN NAME OF MOTHER Martha Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Miss

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JAN 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1922, to Jan 26, 1923, that I last saw him alive on Jan 26, 1923, and that death occurred, on the date stated above, at 9.15 p m.

The CAUSE OF DEATH* was as follows:

Ascending transverse lesion of spinal cord.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Pernicious anemia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Texas

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Thos H Allen, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Paris Texas	Jan 27/23
20 UNDERTAKER	**ADDRESS**
E Hughes	424 N. Elwood

Spec.—1-10-21—M&T—1500 Bks.

71673
D71673

HEALTH DEPARTMENT—CITY OF BALTIMORE

71673

CERTIFICATE OF DEATH.

57 D71673

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 811 N. Wolfe ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence J Fink

(a) RESIDENCE NO. 811 N Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo M. Fink

6 DATE OF BIRTH (month, day, and year) Jan 7th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	—	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Watertown N Y.

PARENTS

10 NAME OF FATHER Emory Leasche

11 BIRTHPLACE OF FATHER (city or town) (State or country) Watertown N.Y.

12 MAIDEN NAME OF MOTHER Kate McEnroe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Geo M. Fink

(Address) 811 N. Wolfe St

15 JAN 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to January 24, 1923, that I last saw her alive on January 24, 1923, and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus - Chronic

Myocarditis (duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory.

(Signed) J. J. Roberts, M. D.

, 19 (Address) 1300 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 24 1923

20 UNDERTAKER Geo M. Fink & Son — ADDRESS 811 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS BLANK CONTAINS THE ONLY RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-002 D71674

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 E. Chase ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Virginia Lauterbach

(a) RESIDENCE. No. 1733 E. Chase ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Daniel Lauterbach

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Mary C Lee

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto.

14 Informant Jno L Lee
(Address) 1920 N. Collington Ave

15 Filed JAN 28 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/22, 1923, to 1/27, 1923, that I last saw her alive on 1/26, 1923, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia bilat.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Infantile Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. Edw Smith M. D.

1/27 1923 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Jan 28 1923

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 Bway

D71675 HEALTH DEPARTMENT—CITY OF BALTIMORE D71675

CERTIFICATE OF DEATH. X 188-011

1-PLACE OF DEATH At Sea, 100 miles Registered No. C.....

City of BALTIMORE: (No. South east of Charleston S.C. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Frederick Johansson.

(Residence in Baltimore: No. Anchorage Hotel. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. January 10th. 1891.
(Month) (Day) (Year)

7-AGE. 32 yrs. ---- mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sea-man
(b) General nature of industry, business, or establishment in which employed (or employer): S/S Nelson.

9-BIRTHPLACE, (State or Country). Finland.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Capt. A.H. Rafuse.

(Address) S/S Nelson. Curtis Bay.

15- FILED JAN 28 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 23rd. 1923. 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Fracture of Skull.
Thrown by a wave against the mast of S/S Nelson.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto K. Reinhardt M.D.
(Coroner.)

Jan. 27. 192. 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Pauls Cem. DATE OF BURIAL. Jan 28 1923

20-UNDERTAKER. H. Sander Sons ADDRESS 1710 Fleet

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71676

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D71676

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1321 N Central Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Borrell

(a) RESIDENCE NO. 1321 N Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 18. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Pablo M. Borrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cuba

12 MAIDEN NAME OF MOTHER Jane F. Bifford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jane F. Borrell

(Address) 1321 N Central Ave

15 JAN 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Jany 24, 19 23, to Jany 26 19 23,

that I last saw h[illegible] alive on Jany 26th 19 23

and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Pancreatitis (Apoplexy)

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Jany 27, 19 23 (Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine.

DATE OF BURIAL Jan 29 1923

20 UNDERTAKER [illegible]

ADDRESS 5022 Reisterstown Ave.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71677

CERTIFICATE OF DEATH.

100-001 D71677

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wilson

(a) RESIDENCE No. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE CONTAINS FOUR COPIES. ALL should be filled out. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [illegible]nknown

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
81	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer) 666

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER George Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Janet Belle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Municipal Hospital Records. (Address)

15 JAN 28 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from January 22, 1923, to January 26, 1923, that I last saw him alive on January 26, 1923, and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

1/27/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL Jan 30 1923

20 UNDERTAKER John D. Sperry & Co ADDRESS 1320 E. Caroline

Tantha Taylor.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71678

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

1 X 179 D71678

Registered No. C.....

City of BALTIMORE: (No. Emergency Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tantha Taylor

(Residence in Baltimore: No. Glenburnie Rd St.; yrs. ..... mos. 1 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Dec. (Month) 19 (Day) 1917 (Year)

7-AGE: 3 yrs. 1 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): A.A. Co. Maryland

PARENTS:

10-NAME OF FATHER: William Taylor

11-BIRTHPLACE OF FATHER, (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Augusta Nickerson

13-BIRTHPLACE OF MOTHER, (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Taylor (father)

(Address) Furnace Branch, Glen Burnie, Md

15- FILED JAN 28 1923 192.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: June (Month) 27 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... (Coroner, autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns on body

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) McCready Ref in Ind

Duration ... yrs. ... mos. ... ds.

(Signed) H. R. Gorsuch M. D. (Coroner)

6-27 192.3 (Address) 117 W Lanvale

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Furnace Branch Cemetery DATE OF BURIAL: June 28 1923

20-UNDERTAKER: John H. Tordim ADDRESS: 142 Wilkens Ave

D71679

HEALTH DEPARTMENT—CITY OF BALTIMORE

1887-005 D71679

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH American Sugar Refining Co.

City of BALTIMORE: (No. Locust Point. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stefan Kostuk.

(Residence in Baltimore: No. 9 E. York St. St.; yrs.,.....mos.....ds.)

?

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Married

6-DATE OF BIRTH. April 26th 1890. 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
32 yrs. 9 mos. ---ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Poland.

PARENTS.

10-NAME OF FATHER, Wasili Kostuk.

11-BIRTHPLACE OF FATHER, (State or Country). Poland.

12-MAIDEN NAME OF MOTHER, Marosia Melnik.

13-BIRTHPLACE OF MOTHER, (State or Country). Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul Tishko. (cousin)

(Address) 223 S. Ann St.

15- Filed JAN 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 26th. 1923. 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Internal injuries.
Caused by the breaking of a revolving sugar machine and struck in the chest by flying parts (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto K. Reinhardt M. D.
(Coroner.)

Jan 27 192 3. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Louden Park	Jan 29 1923
20-UNDERTAKER. John Gretlauch	ADDRESS 425 S. Paca St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71680 — 129 — D71680

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Forest Park — REGISTERED NO. .....

CITY OF BALTIMORE: (No. 3717 Ashburton Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Bornschener.

(a) RESIDENCE NO. 3717 Ashburton Ave ST., 15 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Bornschener

6 DATE OF BIRTH (month, day, and year) Sept. 2nd 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	4		

8 OCCUPATION OF DECEASED Retired Tailor.

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Conrad Bornschend.

11 BIRTHPLACE OF FATHER (city or town) Germany. (State or country)

12 MAIDEN NAME OF MOTHER Katherine Ranft

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Wm Bornschener. (Address) 3717 Ashburton Ave

15 JAN 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to Jan 26, 1923

that I last saw h Malive on Jan 25, 1923

and that death occurred, on the date stated above, at 8.40 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) O. F. Kuntzmann, M. D.

Jan 27, 1923 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Matthews Cem.	Jan 28 1923
20 UNDERTAKER Lilly and Zeile	ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state information in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation. Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Nephritis

D71681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D71681

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2524 W Pratt St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Michael Madeliner

(Residence in Baltimore: No. 2526 W Pratt St., 63 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Jan (Month) 6 (Day) 1834 (Year)

7-AGE. 89 yrs. ..... mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Shoemaker

9-BIRTHPLACE, (State or Country). Austria

PARENTS.

10-NAME OF FATHER. Sebastian Madeliner

11-BIRTHPLACE OF FATHER. (State or Country) Austria

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country) Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lis A Mahrenholt

(Address) 2526 W Pratt St

15-

Filed JAN 28 1923, 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 26 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Fenton M. D. (Coroner.)

Jan 27 1923 (Address) 700 E Chase St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Western Cem DATE OF BURIAL. Jan 29 1923

20-UNDERTAKER. William Cook ADDRESS 502 E Nath Ave.

Spec.—1-10-21—M&T—1500 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 D71682

CERTIFICATE OF DEATH.

99-002 D71682

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 Hartley ST., 16 WARD)

2-FULL NAME Mary Hughes

(a) RESIDENCE NO. 1006 Hartley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Hughes

6 DATE OF BIRTH (month, day, and year) Feb 29 1863

7 AGE Years 59 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Fred Sumler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sue Kerr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James Hughes (Address) 1006 Hartley St.

15 JAN 28 1923 ROBERT R. KRATTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1922, to Jan 27th, 1923.

that I last saw h[illegible] alive on Jan 26, 1923.

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D. S. Jones M. D.

1/27, 1923 (Address) 728 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Valley Cockeysville DATE OF BURIAL Jan. 27 1923

20 UNDERTAKER H. M. Cook ADDRESS 5522 Harford

D71683

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 D71683

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2340 Druid Hill Ave WARD 13)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Jennie Crystal

(Residence in Baltimore: No. 2340 Druid Hill Ave Sr. 28 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Unknown (Month), 1 (Day), (Year)

7 AGE: 80 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Cohen

(Address) 2340 Druid Hill Ave

15 Filed JAN 28 1923

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 28th (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 26th, 1923 to Jan 28th 1923 that I saw h[illegible] alive on Jan 27th, 1923 and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Samuel Weinberg M. D.

Jan 28th, 1923 (Address) 2302 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Hebrew Wo[illegible]

DATE OF BURIAL: Jan 28, 1923

20 UNDERTAKER: Wolf Levin

ADDRESS 1127 E. Baltimore St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PENNEY, WITH SIGNATURE THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D71684 HEALTH DEPARTMENT—CITY OF BALTIMORE

D71684

CERTIFICATE OF DEATH.

118-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5. Cherry. ST., 25 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Ulkowski

(a) RESIDENCE NO. 5. Cherry. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 53 Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): Saw Mill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Anna Klantzowska

(Address) 5 Cherry

15 Filed JAN 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1923, to Jan 26, 1923, that I last saw h[illegible] alive on Jan 26, 1923, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) 5 hrs. mos 1/2 ds.

CONTRIBUTORY (Secondary): Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon L. Warka, M. D.

1/26 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross

DATE OF BURIAL: 1/29 1923

UNDERTAKER: Wm Faulsowski

ADDRESS: 1118 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71685 11-001 D71685

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 N. Bentalou Street ST., 20 WARD)

2-FULL NAME Herman K. Malkmus

(a) RESIDENCE NO. 28 N. Bentalou St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	18	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Malkmus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mrs. Malkmus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Malkmus
(Address) 28 N. Bentalou St.

15 Filed JAN 28 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from January 25, 1923, to January 26, 1923, that I last saw him alive on January 26, 1923 and that death occurred, on the date stated above, at 8. A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia 2 days

Influenza. 4 days

Friedreichs- Ataxia. 18 yr

(duration) ... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Carlahan, —, M. D.

1/27 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetary — DATE OF BURIAL: Jan. 29 1923

20 UNDERTAKER: George A. Farley — ADDRESS: Fayette & Fulton

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71686

CERTIFICATE OF DEATH.

9 D71686

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1402 N. Bethel ST., 8 WARD)

2-FULL NAME Elizabeth Christman Nappel

(a) RESIDENCE NO. 1402 N Bethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W Balt

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): June 7 1922

7 AGE — Years: — Months: 7 Days: 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Edward M Nappel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Bertha E Lacey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Mr Edward M Nappel

(Address) 140- N Bethel St

15 JAN 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-28 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-25, 1923, to 1-28, 1923, that I last saw her alive on 1-28, 1923, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Dianne Nellis, M. D.

, 19 (Address) 1506 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Jan 29 1923

20 UNDERTAKER: Henry Storch Son — ADDRESS: 1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71687 — 188-003 — D71687

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mary M'Chamt

(Residence in Baltimore: No. 431 Hargrave St.; 35 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

6-DATE OF BIRTH. Unknown. ....., 1848
(Month) (Day) (Year)

7-AGE. 75 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER. Jeff. Brannan

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. —

13-BIRTHPLACE OF MOTHER, (State or Country). —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Chamt

(Address) + 31 Hargrave St

15-FILED JAN 28 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 24, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fare
Fract. Skull accidentally
struck by auto.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Jan 28 1923 (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery — DATE OF BURIAL. Jan 29 1923

20-UNDERTAKER. Mrs Robert A Elliott — ADDRESS 1725 Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71688

CERTIFICATE OF DEATH.

74-001 D71688

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 W. Lombard St ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Brooke

(a) RESIDENCE. NO. 1102 W. Lombard St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Felix Brooke

6 DATE OF BIRTH (month, day, and year) May 10, 1860.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert S. Corry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sumploria Oliver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

11 Informant Mrs Samuel Goldberg
(Address) 1102 W. Lombard St

15 JAN 28 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26, 1923.

17 I HEREBY CERTIFY, That I attended deceased from 1/24/23 19 , to 1/26/23 , 19 ,

that I last saw h.. alive on 1/26/23 , 19 ,

and that death occurred, on the date stated above, at 9.50 P.m.

The CAUSE OF DEATH* was as follows:

Chr Hypertension

Con. Dis. of Myocardium

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) Edward J. Young, M. D.

1/27, 1923 (Address) 9 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery.

DATE OF BURIAL: Jan, 29. 1923

20 UNDERTAKER: John F. Cowan & Son. Per F. F. Cowan

ADDRESS: 90. Hollins St.

Spec.—1-10-21—M&T—1500 Blks.

D 71689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D71689

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Windsor Court Apts. ST., 15 WARD)

2-FULL NAME Charles Newton Merritt,

(a) RESIDENCE NO. Windsor Court Apt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate E. Merritt

6 DATE OF BIRTH (month, day, and year): Oct 27, 1850

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
72	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wholesale Produce Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self 045

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co Md.

PARENTS

10 NAME OF FATHER: John Merritt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anne Arundel Co. Md

12 MAIDEN NAME OF MOTHER: Eliza C. Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md

14 Informant: Kate E. Merritt

(Address) Windsor Court Apts

15 FILED JAN 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan-26 1923

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1922, to Jan-26, 1923, that I last saw him alive on Jan-26, 1923, and that death occurred, on the date stated above, at 9. a, m.

The CAUSE OF DEATH* was as follows:

Complications of diseases, due to arteriosclerosis with myocarditis cerebral hemorrhage. Right hemiplegia epileptiform seizures (duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) General malnutrition due to failing circulation (duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? General clinical symptoms.

(Signed) Hurley Cole M. D.

, 19 (Address) 2202 Gormon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Jan 29 1923

20 UNDERTAKER: Wm Fleckner Sons

ADDRESS

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71690

CERTIFICATE OF DEATH.

99-001 D71690

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4003 Forest Park Ave ST.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy L Wolfe

(a) RESIDENCE. NO. 4003 Forest Park Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 27-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER T. Roby Wolfe Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Nellie M Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant T. Roby Wolfe Jr

(Address) 4003 Forest Ave

15 Filed JAN 28 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1923, to Jan. 27, 1923, that I last saw her alive on Jan. 27, 1923, and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute cardiac decompensation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical examination

(Signed) H. E. Wright M. D.

1/28. 1923 (Address) 728 E. 41st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Jan 29 1923

20 UNDERTAKER John Merriat

ADDRESS 2[illegible] Eden

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blp.

D71691

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47

D71691

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1738 Pulaski Mre. ST., 15 WARD)

2-FULL NAME Emma R. Thompson

(a) RESIDENCE No. 1735 Poplar Grove St WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Saml J Thompson

6 DATE OF BIRTH (month, day, and year) Aug 21 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Chapman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susanna Custer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs James R. Wilson

(Address) 1735 Poplar Grove St

15 JAN 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1923, to Jan 27, 1923.

that I last saw her alive on Jan 26th, 1923

and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. R. Driscoll, M. D.

19 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 29, 1923
20 UNDERTAKER	ADDRESS
Josiah Syber	1600 W. Pratt Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D71692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D71692

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Longwood St. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizebeth R. Evans.

(a) RESIDENCE. NO. 1312 Longwood St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22-1846

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wales.

PARENTS

10 NAME OF FATHER Wm D Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales.

12 MAIDEN NAME OF MOTHER Elizebeth Rosser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales.

11 Informant Bessie Brahmanker.

(Address) 1312 Longwood

15 JAN 28 1923 ROBERT R. KRAUTER, Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27/23

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1923 to Jan 27, 1923.

that I last saw her alive on Jan 27, 1923

and that death occurred, on the date stated above, at 12.40 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. R. Mellon, M. D.

(Address) 2757 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland Md. DATE OF BURIAL: Jan 30 1923

20 UNDERTAKER: Josiah Sykes ADDRESS: 1600 N. North

Spec.—1-10-21—M&T—1500 Bks.

71693 D71693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 71693 D71693

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 Essex ST., 1 WARD)

2-FULL NAME Irene J. Hermann

(a) RESIDENCE NO. 2223 Essex ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Maryland

PARENTS

10 NAME OF FATHER George Henry Herman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Maryland

12 MAIDEN NAME OF MOTHER Catherine Bonus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant George Henry Herman
(Address) 2223 Essex St

15 FILED JAN 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1923, to Jan 27, 1923,

that I last saw h alive on Jan. 26, 1923,

and that death occurred, on the date stated above, at 3, P, m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Geo [illegible], M. D.

, 19 (Address) 2818 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL 1/29/1923

20 UNDERTAKER Wm H Wilson & Son — ADDRESS 2503 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Primary

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

This baby has been sick
with Bronchial Pneumonia
for two weeks Last two Other
Physicians Called May 26.
at 9 30 P.M.

Geo L Dilyard M D.

Spec.—1-10-21—M&T—1500 Bks.

71694

D71694

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D71694

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Mosher ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth F. Kaufman

(a) RESIDENCE No. 712 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Kaufman

6 DATE OF BIRTH (month, day, and year): don't Know

7 AGE: Years: about 75; Months; Days; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: John Candle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Lucy Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Louis Kaufman (Address) 712 Mosher

15 Filed JAN 29 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Jan 26, 1923, that I last saw her alive on Jan 26, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart.
Mitral Regurgitation

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Sastritis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Murray, M. D.

Jan 27 1923 (Address) 1221 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 1/29/1923

20 UNDERTAKER: Geo. Weber & Son 2503 Edmondson — ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

71695 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-00 71695

D71695

CERTIFICATE OF DEATH.

D71695

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 Lamont 1316 Lamont ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elizabeth Stamer

(a) RESIDENCE NO. 1316 Lamont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 31st 1920

7 AGE — Years: 2 — Months: 0 — Days: 27 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City Maryland

PARENTS

10 NAME OF FATHER: Charles B. Stamer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Westminster Maryland

12 MAIDEN NAME OF MOTHER: Anita E. Engel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City

14 Informant: Mrs. Charles B. Stamer

(Address) 1316 Lamont ~~ROBERT H. KRAUTER,~~

15 Filed JAN 29 1923 19 ... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 27th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23rd, 1923, to Jan. 27, 1923, that I last saw her alive on Jan. 27th, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) + yrs. + mos 4 ds.

CONTRIBUTORY (Secondary): Cretinism

(duration) Probably about life.

18 Where was disease contracted if not at place of death? +

Did an operation precede death? No Date of +

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) O. H. Stoffregen, M. D.

1-27-1923 (Address) 340 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL 1/29/1923

20 UNDERTAKER: Geo. Weber & Son — ADDRESS 2503 Edmondson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Zahner

Special 1021—M&T—1500 Bks.

D71696

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71696

CERTIFICATE OF DEATH.

117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T Zahner.

(a) RESIDENCE NO. 157 N Curley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Zahner

6 DATE OF BIRTH (month, day, and year) Dec 18, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer.

(b) General nature of industry, business, or establishment in which employed (or employer) 0-30

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Zahner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Schrall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Rose Zahner

(Address) 157 N. Curley St.

15 Filed JAN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 5, 1923, to Jan 27, 1923, that I last saw him alive on Jan 27, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Appendiceal abcess.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Fecal fistula - Pulmonary hemorrhage Cachexia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 5/23 Jan 17/23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Daniel J Pessagno, M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Jan 31 1923

20 UNDERTAKER Lilly and Zeile

ADDRESS 403 S. Woo[illegible]

N. B.—WHERE PHYSICIAN CERTIFIES AGE, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D71697

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2536 Fait Ave. ST., 1 WARD)

2-FULL NAME Caroline M. Honan

(a) RESIDENCE NO. 2536 Fait Ave. ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Wm Honan

6 DATE OF BIRTH (month, day, and year): March 4th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Lambert B Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katherine Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lambert B. Meyer (Father) (Address): 503 S. Eugene Ave.

15 Filed: JAN 29 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1922, to Jan 25, 1923, that I last saw h. alive on Jan 25, 1923 and that death occurred, on the date stated above, at 10 40 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonic Tuberculosis of Lungs

(duration) yrs. 3 mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Examination

(Signed) Eugene Zeller, M. D.

Jan 27 1923 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery — DATE OF BURIAL: Jan. 29 1923

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

Mrs Sadler

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71698

D71698

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 S. Bouldin ST., 26 WARD)

2-FULL NAME David Scott Wilkie

(a) RESIDENCE NO. 103 S. Bouldin ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 5 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26th 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	30	5	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Soldier Invalid

(b) General nature of industry, business, or establishment in which employed (or employer) Totally Disabled

(c) Name of employer 000

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER David A. Wilkie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Beatrice Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Wm W. Wilkie
(Address) 101 S. Bouldin St.

15 Filed JAN 29 1923 HUBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923. to Jan 24, 1923.

that I last saw him alive on Jan, 1924.

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Asc Pulm Oedema.

(duration) yrs. mos 8 hrs.

CONTRIBUTORY Pulm TB
(Secondary)
(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Sadler M. D.

1/26 1923 (Address) 333 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivett Cem. DATE OF BURIAL: Jan 29th 1923

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 403 S Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71699

CERTIFICATE OF DEATH.

90 D71699

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 S Stricker ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine V. Pickett

(Residence in Baltimore: No. 320 S Stricker St.; 15 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, February 29, 1837
(Month) (Day) (Year)

7-AGE, 85 yrs. 11 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Daniel McAllister

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Susan Grindall

13-BIRTHPLACE OF MOTHER (State or Country). Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs George Clary

(Address) 320 S Stricker St

15- FILED JAN 29 1923, 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 26, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 5 1922, to Jan 26 1923, that I saw her alive on Jan 26 1923, and that death occurred, on the date stated above, at 5 10 p.m.

The CAUSE OF DEATH* was as follows:

..... Myocardial Insufficiency .....

..... (Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) Senility

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

Jan 28, 1923 (Address) 626 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Poplar Springs, Howard Co. Md.

DATE OF BURIAL. 1-29, 1923

20-UNDERTAKER Earl B Hale

ADDRESS 115 E West St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71700

CERTIFICATE OF DEATH.

D71700

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1007 Salisbury alley St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Callahan

(Residence in Baltimore: No. 1007 Salisbury alley St.; yrs. 41 mos. 4 ds. 11)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Sept 16 (Month) (Day) 1881 (Year)

7-AGE: 41 yrs. 4 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER, MacKelcey Callahan

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER, Lottie Williams

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Kinnard

(Address) 616 Wayne Ave

15- FILED JAN 29 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 27 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Turner M. D. (Coroner)

Jan 28th 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Ct DATE OF BURIAL: Jan 30 1923

20-UNDERTAKER: J L Brown & Son ADDRESS 1054 N. Monroe

Spec.—1-10-21—M&T—1500 Blu.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71701

CERTIFICATE OF DEATH.

90 D71701

REGISTERED NO.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. 5 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred L. Wilson

(a) RESIDENCE NO. 410 N. Front St, City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Grace Wilson

6 DATE OF BIRTH (month, day, and year) March 15, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 JAN 29 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27 1922 to Jan. 25 1923

that I last saw him alive on Jan. 25 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

~~Chronic~~ Myocardial Insufficiency

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Renal, Tic jaundice

(duration) 30 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. L. Bugg M. D.

1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL Jan 28 1923

20 UNDERTAKER Peter Nicolaus ADDRESS 2060 East 22

N. B.—WHITE PAPER, WITH CARBON SHEET BETWEEN. PHYSICIANS should state AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This is very important.

Shemm.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D71702

CERTIFICATE OF DEATH

24-001 D71702

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 1528 Ashland Ave ST. 7 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sarah Amelia Shemm

(Residence in Baltimore: No. 1528 Ashland ave. St.; 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): widowed

6 DATE OF BIRTH: Jan. (Month) 10th (Day), 1864 (Year)

7 AGE: 59 yrs. — mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): — — 070

9 BIRTHPLACE (State or country): British. Guiana

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Sarah Field

13 BIRTHPLACE OF MOTHER (State or country): Unknown.

14 I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter. Shemm.

(Address) 1528 Ashland ave.

15 Filed JAN 29 1923, 191 — ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 1 (Month) — 26 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-24-, 1923, to 1-26-, 1923, that I saw h[illegible] alive on 1-25-, 1923, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds

Contributory (SECONDARY) Hardening of [illegible]; [illegible]

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) [signature] M. D.

1-27-, 1923 (Address) 64 N Carolina

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Jan 29 1923

20 UNDERTAKER: Milton Davis — ADDRESS: 315 N Edw...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71703 ✓ D71703

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1409 Bolton ST.; 14 57 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Wm. M. Dame

(a) RESIDENCE. No. 1409 Bolton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan M. Finstine

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clergyman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

018

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Geo. W. Dame

11 BIRTHPLACE OF FATHER (city or town) (State or country) New. Hamp

12 MAIDEN NAME OF MOTHER Mary Page

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Rev. Page Dame
(Address) 1409 Bolton St.

15 JAN 29 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1922, to Jan 27, 1923, that I last saw him alive on Jan 27, 1923, and that death occurred, on the date stated above, at 11.45 P.m.

The CAUSE OF DEATH* was as follows:
Diabetes -, Chronic Nephritis, Myocarditis,

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas W. Lamond, M. D.

, 19 (Address) 1327 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	Jan 29, 1923

20 UNDERTAKER John O Mitchell ADDRESS 2201 W. Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71704

CERTIFICATE OF DEATH.

100-001

D71704

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3510 Roland Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Thomas Martin

(a) RESIDENCE NO. 3570 Roland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) March 23 1918

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
4	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm H Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma D Simpson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm H Martin (Address) 3510 Roland Ave

15 JAN 29 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to Jan 26, 1923, that I last saw him alive on Jan 26, 1923, and that death occurred, on the date stated above, at 11.45 A.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H Horwitz M. D.

, 1923 (Address) 3631 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Jan 29 1923

20 UNDERTAKER Eichenauer & Son ADDRESS Chestnut ave

N. B.—WARNING—PHYSICIANS and UNDERTAKERS will be liable to prosecution if they fail to comply with the requirements of the law governing the registration of deaths. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71705

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71705

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1356 N. Calhoun St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Edna Reeder

(Residence in Baltimore: No. 1356 N. Calhoun St. 18 yrs., ✱ mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) married

6-DATE OF BIRTH. Oct. 11 (Month) (Day) 1894 (Year)

7-AGE, 28 yrs. 3 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cook
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Daniel Wormley

11-BIRTHPLACE OF FATHER, (State or Country), Va.

12-MAIDEN NAME OF MOTHER, DK

13-BIRTHPLACE OF MOTHER, (State or Country), DK

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Reeder

(Address) 1354 N. Calhoun St

15- Filed JAN 29 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Jan 26 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) ....

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Jan 26 1923 (Address) 2 E Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, W. Arbutus — DATE OF BURIAL, Jan 29 1923

20-UNDERTAKER, Sam P. Trail — ADDRESS 1400 Monroe

Spec.—8-24-14—M. & T.—2000 Bks.

D71706

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002 D71706

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 N Arlington Ave St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Levi Kellum Sr

(Residence in Baltimore: No. 1036 N Arlington ave St.: 4 yrs. ..... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Widowed

6-DATE OF BIRTH, Unknown (Month) ....., 1853 (Year)

7-AGE, 70 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Farmer

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER Bridget Kellum

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Levi Kellum Jr.,

(Address) 1036 Arlington Ave

15. Filed JAN 29 1923, 191..... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 26, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 20 1923, to Jan. 26 1923, that I saw him alive on Jan. 25 1923, and that death occurred, on the date stated above, at 2.35 P m.

The CAUSE OF DEATH* was as follows:

..... Influenza

..... (Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. T. Carr M. D.

Jan 28, 1923 (Address) 5 S Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, Jan 29 1923

20-UNDERTAKER Samuel Hendry — ADDRESS 578 N Eden

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71707

CERTIFICATE OF DEATH.

99-001-
D71707

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 245 S. Caroline ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Waclaw Jagelski

(a) RESIDENCE NO. 245 S. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4-	2	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Bronislaw Jagelski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Victoria Lewandowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Bronislaw Jagelski

(Address) 245 S. Caroline St.

Filed JAN 29 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1923, to Jan. 27, 1923, that I last saw him alive on Jan 26, 1923 and that death occurred, on the date stated above, at 11½ A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Catarrh

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rehberger M. D.

, 19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. DATE OF BURIAL Jan 29 1923.

20 UNDERTAKER Jacob D. LeRoux ADDRESS 428 S. Bond St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71708

CERTIFICATE OF DEATH.

162 D71708

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1203 W. Lexington St.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Shaffrey

(a) RESIDENCE. No. 1203 W. Lexington St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan - 28 - 23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 20 min.
✓	✓	-	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm O. Shaffrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Agnes M. Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Agnes M. Shaffrey (Address) 1203 W. Lexington St.

15 Filed JAN 29 1923 ROBERT R. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28. 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 28, 1923, to Jan 28, 1923, that I last saw h[illegible] alive on Jan 28, 1923, and that death occurred, on the date stated above, at 5-35 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis,

(duration) Twenty Minutes

CONTRIBUTORY (Secondary) Breech Presentation delaying Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry F. Ortel, M. D.

Jan 28 1923 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Jan 29 1923

20 UNDERTAKER John F. Howard & Son, Per J. F. Howard. ADDRESS 901 Hollins St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

O'Connell

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71709 ✓ D71709

CERTIFICATE OF DEATH.

111-60

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (NO. St Joseph's Hospital ST.: 7 WARD 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J Connell

(a) RESIDENCE. NO. 1032 Mc Donough St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life 21 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 17-1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Dennis J Connell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Catherine Connell (Address) 1032 Mc Donough St

15 Filed JAN 29 1923, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1922, to Jan 26, 1923, that I last saw him alive on Jan 26, 1923, and that death occurred, on the date stated above, at 8:10 A. m.

The CAUSE OF DEATH* was as follows:

Subphrenic Abscess (perforating Duodenal Ulcer)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septic Meningitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of Nov 26, 1922

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & Clinical Findings

(Signed) Geo. L. Wrasley, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Most Holy Redeemer	JAN 30 19
20 UNDERTAKER	ADDRESS
F B Dupont	220 E Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

Bokee.

D71710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71710

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Asylum ST., 220 WARD)

2-FULL NAME Annie Bokee

(a) RESIDENCE NO. 2109 Mc Henry St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. ~~11~~ mos. ~~18~~ ds. How long in U. S., if of foreign birth? ~~72~~ yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Bokee

6 DATE OF BIRTH (month, day, and year): Feb 10-1850

7 AGE: Years 72 | Months 11 | Days 18 | If LESS than 1 day, ...hrs or ....min.

8 ~~OCCUPATION~~ OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Annie Hayes 2109 Mc Henry St

15 Filed JAN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1922, to Jan 27, 1923,

that I last saw h.m alive on Jan. 27, 1923,

and that death occurred, on the date stated above, at 6:50 a. m.

The CAUSE OF DEATH* was as follows:

Senile Gangrene of left foot

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ogden Neil, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Cemetery DATE OF BURIAL, 19: Jan 31

20 UNDERTAKER: F. B. Heppe & Sons ADDRESS: Fredk Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71711

CERTIFICATE OF DEATH.

1474-001

D71711

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1535 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J. Phillips

(Residence in Baltimore: No. 1535 Division St. 57 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 57 years ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, William Ball

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER mary L. Dobson

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lottie Ball

(Address) 1535 division st

15-

Filed JAN 29 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 26, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 17 1923, to Jan. 26 1923, that I saw h.er alive on Jan. 23 1923, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Cer.

Cerebral Hemor-

rhage

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Coma

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) ..... M. D.

Jan 27 1923 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Jan 29, 1923

20-UNDERTAKER John H. Jardwin

ADDRESS 142 Hill St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71712

CERTIFICATE OF DEATH.

43

D71712

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Asylum St., Ward 15)

2-FULL NAME John A Kelley

(a) RESIDENCE No. 2018 Druid Hill Ave. St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Angelina Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Anna Keeley

(Address) 2018 Druid Hill Ave

15 JAN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1923, to Jan 27, 1923.

that I last saw him alive on Jan 27, 1923.

and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of floor of mouth

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 22, 1923

Was there an autopsy?

What test confirmed diagnosis? Microscopical exam

(Signed) Clyde M Neill, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Jan 30 1923
20 UNDERTAKER	ADDRESS
John H Todd	142 Mine St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D71713

REGISTERED NO.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 186 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paula Hoffman

(a) RESIDENCE No 1008 Mineola Ave City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 25 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Fred Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Cassie Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 29 1923 ROBERT R. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1923, to Jan. 28, 1923, that I last saw her alive on January 28, 1923, and that death occurred, on the date stated above, at 2 45 A. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 4 mos 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? —

(Signed) A. F. Wesch, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem Baltimore Md — DATE OF BURIAL Jany 20 1923

20 UNDERTAKER Harry W. Ehlen — ADDRESS 1944 N. North Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malnutrition

D71714

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71714

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1449 N. Fulton Ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob C. Fehler

(Residence in Baltimore: No. 1449 N. Fulton Ave. St.; yrs. 44 mos. 10 ds. 8)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	married

6-DATE OF BIRTH. March 15, 1878 (Month) (Day) (Year)

7-AGE. 44 yrs. 10 mos. 8 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: marble setter
(b) General nature of Industry, business, or establishment in which employed (or employer): 176

9-BIRTHPLACE. (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER. Herman Fehler

11-BIRTHPLACE OF FATHER. (State or Country): Germany

12-MAIDEN NAME OF MOTHER. Catherine Pelsey

13-BIRTHPLACE OF MOTHER. (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August Kirdl

(Address) 1931 N. Fulton Ave

15-

Filed JAN 29 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan. 26 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, au- (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(Duration) ? yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Jan 27 1923 (Address) 2.50 E. Lexington St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem.	Jany 30, 1923
20-UNDERTAKER. Harry W. Ehlen	ADDRESS 1944 W. North ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

Bunn.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71715

CERTIFICATE OF DEATH.

1729 D71715

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1327 N. Luzerne ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edw L Bunn

(Residence in Baltimore: (No. 1327 N Luzerne St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, married OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Dec 28, (Month) (Day) 1846 (Year)

7-AGE, 77 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), N. J.

PARENTS.

10-NAME OF FATHER, John Bunn.

11-BIRTHPLACE OF FATHER (State or Country), N. J.

12-MAIDEN NAME OF MOTHER Eliza Smith

13-BIRTHPLACE OF MOTHER (State or Country), N. J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw L Bunn

(Address) 1327 Luzerne st

15- Filed JAN 29 1923, 191..... ROBERT R. KRAUTER, Burial Permit Clerk.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 25, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1920, to Jan 25 1923, that I saw h[illegible] alive on Jan 25, 1923, and that death occurred, on the date stated above, at 12 M. a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and

Chronic Nephritis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) 0 yrs. ..... mos. ..... ds.

(Signed) Allan G. Ingraham M. D.

1/26/, 1923 (Address) 1613 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Bellmore Cemty — DATE OF BURIAL, Jan 29, 1923

20-UNDERTAKER, Robt J Turner Sons — ADDRESS 1402 E. Broadway

U.S. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71716

CERTIFICATE OF DEATH.

100-001

D71716

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for the Aged of the M.E. St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mary E Bobze

(Residence in Baltimore: No. 400 N. Fulton Ave St.; 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH, October (Month) 10 (Day), 1847 (Year)

7-AGE, 75 yrs. 3 mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Christyer Hays

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Susan Stroman

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Landry

(Address) 400 N. Fulton Ave

15- JAN 29 1923 Filed, 191 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jany (Month) 27 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 17 1923, to Jany 27 1923, that I saw her alive on Jany 25 1923, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pericarditis

(Duration) yrs. 3 mos. ds.

(Signed) Geo. C. Brannon M. D.

1/27, 1923 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Penn

DATE OF BURIAL, 1/29, 1923

20-UNDERTAKER George J Smith

ADDRESS 1532 Hollins

(1) Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71717

CERTIFICATE OF DEATH.

90 D71717

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Glyndon Ave ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Womeike

(a) RESIDENCE. No. 1312 Glyndon ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): June 5. 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	16	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sheet metal Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Balto Gas Appliance Co

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Joseph Womeike

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Martha Womeike

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Martha Hobanic

(Address) 1342 Glyndon Ave.

15 Filed JAN 29 1923, 19

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 27th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1923, to Jan 27/23, 19..., that I last saw him alive on Jan 26/23, 19..., and that death occurred, on the date stated above, at 1. 4. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis & acute nephritis

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) ... yrs. ... mos. 12 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

Signed Jno B Kolb, M. D.

Jan 29, 1923 (Address) 120 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan. 30. 1923

20 UNDERTAKER: Mrs & S. John H. Teufel & Son ADDRESS 801 W. Fayette St

Spec.—1-10-21—M&T—1500 Bks.

D71718

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 129 D71718

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (NO. ..... ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry L. Smith

(a) RESIDENCE NO. ..... Ruxton, Maryland. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 17 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Harry L. Smith

6 DATE OF BIRTH (month, day, and year) April 8th 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Gardner

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Country Estate

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ..... Maryland.

PARENTS

10 NAME OF FATHER George A. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) ..... Maryland.

12 MAIDEN NAME OF MOTHER Ella Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ..... Maryland.

14 Informant Mr. George Smith

(Address) Rockland Baltimore Co.

15 JAN 29 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 27th 1923

17 I HEREBY CERTIFY, That I attended deceased from January 11th, 1923, to January 27th, 1923,

that I last saw him alive on January 27th, 1923,

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute exacerbation of chronic nephritis

(duration) about yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) Cardio-renal hypertension

(duration) about 1 yr. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical picture + laboratory

(Signed) Jno. T. Finney Jr., M. D.

Jan 27th 1923 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cem	Jan 30th 1923
20 UNDERTAKER	ADDRESS
John Burns Sons	Towson Md

I. B. When funeral, burial or cremation is to be made, this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71719

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71719

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. No 185 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Teodor Kreidich

(Residence in ~~Baltimore~~: No. 592 Robert ave Colgate Md St.; yrs., 15 mos. ds.)
Graceland Park

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced. (Write the word.) Single

6-DATE OF BIRTH. ..... 1.....
(Month) (Day) (Year)

7-AGE. 26 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer). 540

9-BIRTHPLACE, (State or Country). Russia Poland

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country) Russia Poland

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Russia Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Mentzer

(Address) 1000 S. Kenwood Ave

Filed JAN 29 1923 192.... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 27 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture Skull Fall down stairs

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. S. Walker M. D.
(Coroner.)

1-29 1923 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cem. DATE OF BURIAL, Jan. 29 1923

20-UNDERTAKER, Stephen J. Fialkowski ADDRESS 1000 S. Kenwood Ave

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Jennie Dishroom

D71720

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71720

CERTIFICATE OF DEATH.

94-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 S Bethel ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Jennie dishroom

(a) RESIDENCE. No. 203 S Bethel ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colord	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 27. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1 Year			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore MD
(State or country)

PARENTS

10 NAME OF FATHER Elias dishroom

11 BIRTHPLACE OF FATHER (city or town) MD
(State or country)

12 MAIDEN NAME OF MOTHER Louisa turner

13 BIRTHPLACE OF MOTHER (city or town) MD
(State or country)

14 Informant Elias Turner
(Address) 203 S Bethel

15 JAN 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26th 1923, to Jan 26th 1923, that I last saw h[illegible] alive on " " 1923, and that death occurred, on the date stated above, at 3. A m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Jacob L. Wimmer, M. D.

1-27, 1923 (Address) 308 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Burgs cemetery	Jan 29 1923
20 UNDERTAKER	ADDRESS 1631
Edward Bryan	Orleans

D71721

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D71721

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hosp St.) 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Hanson

(Residence in Baltimore: No. 1642 Congress Court St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	

6-DATE OF BIRTH. July (Month) 17 (Day) 1920 (Year)

7-AGE. 2 yrs. 6 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Albert Hanson

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary Smith

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Smith Hanson

(Address) 1642 Congress St

15- Filed JAN 29 1923 192.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 27 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronch. Pneumonia

Some unknown Autopsy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner.)

1-25 1923 (Address) [illegible]

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
mt zion cemetery	Jan 30 1923
20-UNDERTAKER. Edward Barton	ADDRESS 631 Orleans St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Harman

D71722 HEALTH DEPARTMENT—CITY OF BALTIMORE D71722

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 717 Wilmington Ave ST., 20 WARD)

2-FULL NAME Ellen Louise Harman

(a) RESIDENCE NO. 717 Wilmington Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Harman

6 DATE OF BIRTH (month, day, and year) Sept 12 1860

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER James H Burruss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Emily J Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma L Downey

(Address) 407 Hollins Ave

15 Filed JAN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1923 to Jan 27 1923, that I last saw her alive on Jan 27 1923 and that death occurred, on the date stated above, at 12 00 AM m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Rt Sided
(Apoplexy)
Arteriosclerosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Endocarditis Chronic

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert C Mitsch M. D.

1/28/23 (Address) 257 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Jan 30 1923
20 UNDERTAKER	ADDRESS
Wm Cook & Son	Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—[illegible]—M. & T.—2000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71723

CERTIFICATE OF DEATH.

15-007 D71723

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Moreland Ave St.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Sarah J. Smith

(Residence in Baltimore: No. 1700 Moreland Ave St.; about 20 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec. (Month) 25. (Day), 1848. (Year)

7-AGE, 74 yrs. 1 mos. 4 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): 53

9-BIRTHPLACE, (State or Country), Baltimore Co. Md.

PARENTS.

10-NAME OF FATHER, Smallwood Orem.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Susan Knight

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. A. F. Hipsley

(Address) 1700 Moreland Ave

15- FILED JAN 29 1923 191.... ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jany (Month) 28 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 1 1923, to Jany 28 1923, that I saw her alive on January 27 1923, and that death occurred, on the date stated above, at 10 45 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(Duration) 1 yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Paraplegia (Right)

(Duration) 1 yrs. 2 mos. 5 ds.

(Signed) George C. Shannon M. D.

1/28, 1923 (Address) 700 Fulton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hardy Chapel DATE OF BURIAL, Jan 30., 1923

20-UNDERTAKER, William Cahoe ADDRESS 502 E Pratt

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71724

CERTIFICATE OF DEATH.

31 D71724
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Childrens Hospital School WARD) Greenmount Ave + 41st St.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles SCHAMMEL

(Residence in Baltimore: No. 1711 Clifton Ave St. yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Child

6-DATE OF BIRTH, September 15, 1910 (Month) (Day) (Year)

7-AGE, 12 yrs. 4 mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Geo Schammel (Deceased)

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Katharine Furien

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christ. J. Schammel

(Address) 1711 Clifton Ave

15 JAN 29 1923 Filed, 191

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 28th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1919, to January 27 1923, that I saw h last alive on January 27th 1923, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculosis of Spine

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Amyloid Degeneration of

Liver & kidneys (Duration) 4 yrs. mos. ds.

(Signed) Robert W. Johnson M. D.

Jan 28, 1923 (Address) 4 E. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs. mos. ds. In the State 12 yrs. mos. ds.

Where was disease contracted, if not at place of death? At his home

Farmer or usual residence 1717 Eastern Ave.

19-PLACE OF BURIAL OR REMOVAL, Schwartz County DATE OF BURIAL, Jan 31, 1923

20-UNDERTAKER Wilkens & Sons ADDRESS E Mad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71725

CERTIFICATE OF DEATH.

9 D71725

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 W. Beverly ST., 23rd WARD)

2-FULL NAME Charles Chester Crowe

(a) RESIDENCE NO. 126 W. Beverly ST., 23rd WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 7 mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	5	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Hubert Crowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lottie Hampton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.

14 Informant Mrs Lottie Crowe
(Address) 126 Beverly St

15 JAN 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23rd, 1923. to Jan. 28th, 1923.
that I last saw him alive on Jan. 27th, 1923
and that death occurred, on the date stated above, at 9 10 a m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Harry Weibel M.D.

1/28, 1923 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilbur Md DATE OF BURIAL Jan 30 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E Lem

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71726

100-001

CERTIFICATE OF DEATH.

D71726

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Hofmeyer

(a) RESIDENCE NO. 1121 Asquith St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
58	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Bullock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dublin

12 MAIDEN NAME OF MOTHER Mary Lord

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Municipal Hospital Records. (Address)

15 JAN 29 1823 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26 19 23

17

I HEREBY CERTIFY, That I attended deceased from January 11, 19 23, to January 26. 19 23.

that I last saw her alive on January 26, 19 23,

and that death occurred, on the date stated above, at 12:00 P M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Clyde Mace M. D.

1/27/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan 30 1923

20 UNDERTAKER George F. Ruth ADDRESS 1735 Harford Ave

N. B.—BLANKS, WITH ONE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Gosnell

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71727

CERTIFICATE OF DEATH.

11-001

D71727

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 Penna Ave ST. 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alverter Gosnell

(Residence in Baltimore: No. 2010 Pa. St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Feb. (Month) 11 (Day), 1880 (Year)

7-AGE, 42 yrs. 11 mos. 15 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Augustus Gosnell

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Butler

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Gosnell (Son)

(Address) 2010 Penna Ave.

15- Filed JAN 29 1923, 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit C...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 26 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/22 — 1923, to 1/26 — 1923, that I saw h.. alive on 1/26 — 1923, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Influenza
Complication of Diseases

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. R. Smith M. D.

1/26, 1923, (Address) 713 W. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, Jan. 29; 1923

20-UNDERTAKER Geo. W. Johnson

ADDRESS 1234 Eden St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71728

CERTIFICATE OF DEATH.

162

D71728 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 S. Curley ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Kerner

(a) RESIDENCE. No. 109 S Curley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 22/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Herman M Kerner

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Hohn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Herman M Kerner
(Address) 109 S Curley St

15 Filed JAN 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1923, to Jan 29, 1923

that I last saw h~~e~~ alive on Jan 28, 1923

and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia Double

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alma B Lemmon, M. D.

1/29, 1923 Address 718 N Pulaski St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	1/29 1923

20 UNDERTAKER Philip Hennig ADDRESS 2016 Orleans

Spec.—5-19-13—M. & T.—500 Blks.

D71729

HEALTH DEPARTMENT—CITY OF BALTIMORE

Comber

90 D71729

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 Harlem Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Comber

(Residence in Baltimore: No. 1105 Harlem Ave St.; 45 yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-~~SEX~~ Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, unknown (Month) (Day), 1844 (Year)

7-AGE, 79 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Daniel Whalen

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Julia Brennan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie M Shea

(Address) 1105 Harlem Ave

15-

Filed JAN 29 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 27th (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1922, to January 27th 1923, that I saw her alive on January 27th 1923, and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arterio Sclerosis

(Duration) 7 yrs. mos. ds.

(Signed) D Howard Hyatt M. D.

1-27-23, 1923 (Address) 26 E Eager St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, 1-30-..., 1923

20-UNDERTAKER H C Cunningham

ADDRESS 517 N. Schroeder St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71730

CERTIFICATE OF DEATH.

45 D71730

REGISTERED NO. C.....

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. 1000 Monument St.; Ward 19)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Snyder

(Residence in Baltimore: No. 1 N. Calhoun St.; ..... yrs., 1 mos. 4 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, Dec 15, 1878 (Month) (Day) (Year)

7-AGE, 45 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Butcher
(b) General nature of Industry, business, or establishment in which employed (or employer): 0/3

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Abraham Snyder

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Sarah Bear

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis

(Address) 1439 E Balto St

15- Filed JAN 29 1923, 191.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 28, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 23rd 1923, to Jan 28 1923, that I saw him alive on Jan 28 1923, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(Duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum ?

(Duration) ? yrs. mos. ds.

(Signed) Harry Krauss M. D.

1/27, 1923 (Address) Hebrew Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4/3 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence Russia

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rosh Rd

DATE OF BURIAL, 1-29, 1923

20-UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto

Spec.—8-24-14—M. & T.—2000 Bks.

D71731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

70 D71731
REGISTERED No. C.....

1-PLACE OF DEATH Hebrew Hospital 6
CITY OF BALTIMORE: (No..... ST.;..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Rose Arnold
(Residence in Baltimore: No. 26 N. Bond St.; 25 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Married

6-DATE OF BIRTH: Oct 9, 1896 (Month) (Day) (Year)

7-AGE: 26 yrs. mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Benj Blumenthal
11-BIRTHPLACE OF FATHER (State or Country): Russia
12-MAIDEN NAME OF MOTHER: Dora Carmel
13-BIRTHPLACE OF MOTHER (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): J Lewis
(Address): 1439 E Balto St

15- Filed JAN 29 1923 19... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: January 28, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 8 1923, to January 28 1923, that I saw her alive on January 28 1923, and that death occurred, on the date stated above, at 5 41 a.m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia
Hypostatic congestion

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Brain abscess
(Duration) yrs. 8 mos. 26 ds.

(Signed) Louis Lewis M. D.
1-28..., 1923 (Address) Hebrew Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. 20 ds. In the State 18 yrs. mos. ds.
Where was disease contracted, if not at place of death? At Home
Former or usual residence 26 N Bond St

19-PLACE OF BURIAL OR REMOVAL: Hebrew Rodeph Rem
DATE OF BURIAL, Jan 29, 1923

20-UNDERTAKER: Jack Lewis
ADDRESS 1439 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71732

CERTIFICATE OF DEATH.

9 D71732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2513 Garrison Ave. ST., 15 WARD)

2-FULL NAME Adele Perl

(a) RESIDENCE NO. 2513 Garrison Ave., ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Isadore Perl

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Pauline Goldstein

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Isadore Perl
(Address) 1439 E Baltimore St

15 JAN 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1923, to Jan 29, 1923, that I last saw her alive on Jan 28, 1923, and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edgar B Friedenwald, M. D.

, 19 (Address) 1616 Linden Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kehrum Mt Carmel

DATE OF BURIAL: 1-29 1923

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71733 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D71733

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 S Castle ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E Bradyhouse

(a) RESIDENCE NO. 324 S. Castle ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Margaret Bradyhouse

6 DATE OF BIRTH (month, day, and year) Mar 17 1855

7 AGE: Years 67 Months Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)

PARENTS

10 NAME OF FATHER Thos. Bradyhouse

11 BIRTHPLACE OF FATHER (city or town) City (State or country)

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) City (State or country)

14 Informant John Bradyhouse (Address) 324 S Castle St

15 JAN 29 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/21, 1923, to 1/25, 1923, that I last saw him alive on 1/24, 1923, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) Thos A Bradyhouse, M. D.

1/24, 1923 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery Co — DATE OF BURIAL 1/29 1923

20 UNDERTAKER J. A. Moran — ADDRESS 3000 E Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-16-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71734

CERTIFICATE OF DEATH.

10 D71734

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 N. Lakewood ST., 7 WARD)

2-FULL NAME Virginia A. Schultz

(a) RESIDENCE NO. 502 N. Lakewood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14 / 196

7 AGE — Years 6 — Months 6 — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Charles B. Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Agnes E. Dries

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Charles Schultz
(Address) 502 N. Lakewood

15 FILED JAN 29 1923 ROBERT R. KRAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29 1923

17 I HEREBY CERTIFY, That I attended deceased from January 19, 1923, to January 29, 1923, that I last saw her alive on January 29, 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pharyngeal Diptheria

(duration) ..... yrs. ..... mos 12 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) Edema Lungs yrs. ..... mos 2 ds.

18 Where was disease contracted if not at place of death? St Elizabeths School

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. G. Geyer M. D.

, 19 (Address) 541 N. Melton Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baly Redeemer — DATE OF BURIAL Jan. 30, 1923

20 UNDERTAKER Jos. J. Herr — ADDRESS 156 N. Luzerne

Spec.—1-10-21—M&T—1500 Bks.

Ziziolek ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 D71735

D71735

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 S Bethel ST., 2 WARD)

2-FULL NAME Michael Ziziolek

(a) RESIDENCE NO. 526 S Bethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Ziziolek

6 DATE OF BIRTH (month, day, and year) September 26 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michal Ziziolek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Frances Harcalr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Frances Ziziolek

(Address) 526 S Bethel St

15 JAN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23 - 1923, to Jan 26 - 1923.

that I last saw h — alive on Jan 26 1923

and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Senile Deg. arteries of heart (duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) [illegible], M. D.

, 19 (Address) 125 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Jan 30 1923

20 UNDERTAKER John M Weber — ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X25-001

D71736

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2215 Elting St., (Ward) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Booth.

(a) RESIDENCE NO. 2215 Elting St., WARD Augusta

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Gloucester Co Va

PARENTS.

10 NAME OF FATHER: Robert Burrell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Gloucester Co Va

12 MAIDEN NAME OF MOTHER: Maggie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Gloucester Co Va

14 Informant: Franklin Booth

(Address) 2215 Elting St.

15 Filed JAN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/2 17, 1923, to 1/27, 1923,

that I last saw h[illegible] alive on 1/27, 1923,

and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Chicken Pox - with 6 mos pregnancy -

Ac. Congestion of Lung & Ac. Uremia - following

Septicemia - -

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Septicemia -

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo R Butler, M. D.

1/28, 1923 (Address) 2137 Dill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cherry Grove Gloucester Co Va.

DATE OF BURIAL: Jan 29 1923

20 UNDERTAKER: Edward Ruggold

ADDRESS 1463 Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D71737

D71737

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. FORT MCHENRY, BALTO., MD. ST., 3 WARD)

2-FULL NAME SHERIDAN, Joseph

(a) RESIDENCE No. 1000 W. Pratt St., Baltimore, Md., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Married, Widowed, Divorced
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): --

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Broom maker

(b) General nature of industry, business, or establishment in which employed (or employer): --

(c) Name of employer: --

9 BIRTHPLACE (city or town) (State or country): -- Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown "

12 MAIDEN NAME OF MOTHER: Unknown "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Hospital Records

(Address) Fort McHenry, Md.

15 Filed JAN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 26 1923

17 I HEREBY CERTIFY, That I attended deceased from April 3rd, 1922, to Jan. 26, 1923, that I last saw him alive on January 26, 1923, and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic, Far Advanced, active; Tuberculous laryngitis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculous toxaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? U.S. Army

Did an operation precede death? No Date of

Was there an autopsy? Nor

What test confirmed diagnosis? Sputum positive for TB Bacilli.

(Signed) H B Kline, M. D.

Surgeon (R)

1/26 1923 (Address) U.S. Veterans Hospital #56, Fort McHenry, Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemet

DATE OF BURIAL: 1/29 1923

20 UNDERTAKER: H. Leinow & Bro

ADDRESS 1127 E Balto. St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71738

CERTIFICATE OF DEATH.

11-002

REGISTERED NO. D71738

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 514 E. 36th St. (St.) 4 (Ward)

2-FULL NAME Rose Cohen

(a) RESIDENCE. No. 514 E. 36th St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Cohen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Jacob Salty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fanny Caplin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Albert Cohen (Address) 514 E 36th St.

15 Filed JAN 29 1923, 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 24th, 1923, to Jan 28th, 1923, that I last saw her alive on Jan 28th, 1923, and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. H. Mengotroyd M. D.

1/29/23 (Address) 401 E 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rising Run	1/29 1923
20 UNDERTAKER A. Levinson & Bro.	ADDRESS 1127 E. Baltimore St

INFORMATION REQUIRED BY LAW—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REG. NO. 2001

DATE .....

DR. GEO. W. MURGATROYD

401 E. 25TH STREET — PHONE, HOMEWOOD 1582

OFFICE HOURS:
8 TO 10 A. M.
7 TO 8 P. M.
SUNDAY 8 TO 10 A. M.

℞ PATIENT'S NAME ..... ADDRESS .....

Dr. Thompson Jones
Dear Sir
Please change
age on death certificate of Mrs
Rose Cohen sex F. 36 Yrs 8 Mos
44 yrs 4 mos.
Respectfully
Geo. W. Murgatroyd

FULL NAME ..... M. D.

Spec.—1-10-21—M&T—1500 Bks.

Schminger

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71739

CERTIFICATE OF DEATH.

90 D71739

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Schamminger.

(a) RESIDENCE NO. 718 S. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	color	widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto.
(State or country) md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) Unk

14 Informant Lena Eberle
(Address) 718 S. Curley

15 JAN 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 19, 1923, to Jan 27, 1923,

that I last saw him alive on Jan 27, 1923,

and that death occurred, on the date stated above, at 10:40 P m.

The CAUSE OF DEATH* was as follows:

Erysipelas.

(duration) — yrs. — mos 14 ds.

CONTRIBUTORY (Secondary) chr. myocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Morrow Hospital

Did an operation precede death? Prostatectomy Date of 1/10/23

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) B. MacLaren, M. D.

1/29/23 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Matthews Cemetery	Jan 31 1923
20 UNDERTAKER	ADDRESS
H. Vander & Sons	1710 Pat 27

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71740

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-002

D71740

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5501 O'Donnell St. cor. 22nd 26 WARD)
(Mt. Carmel Road.)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Knight Jr.

(a) RESIDENCE. NO. 5501 O'Donnell St. ST. 26 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none - infant

6 DATE OF BIRTH (month, day, and year): Sept 10 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): infant

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Thomas Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Estella May Schmelcle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Estelle M. Knight (Mother)
(Address) O'Donnell & 22nd St.

15 Filed ....., 19 ....
JAN 29 1923
ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1923, to Jan 27, 1923, that I last saw h.. alive on Jan 25, 1923, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary): asphyxia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. W. Wright, M. D.

19 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 29 1923

20 UNDERTAKER: H. Sander & Sons ADDRESS: 1710 Fleet St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71741

11-001 D71741

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 S. Milton Ave ST., 1 WARD)

2-FULL NAME Joseph Howard Horner.

(a) RESIDENCE NO. 710 S. Milton ST., 1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22nd 1920

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
2		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry J. Horner.

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Augusta A. Hulse

13 BIRTHPLACE OF MOTHER (city or town) Chicago Ill
(State or country)

14 Informant Henry J. Horner.
(Address) 710 S. Milton Ave.

15 JAN 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15th, 1923, to Jan 27th, 1923,

that I last saw he alive on Jan 26th, 1923,

and that death occurred, on the date stated above, at 2 45/a. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

Influenza -

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] J. Gilmer, M. D.

Jan 28th, 1923 (Address) 1400 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery — DATE OF BURIAL: Jan 29 1923

20 UNDERTAKER: Ludy & Zeiler — ADDRESS: 403 N. Fulton Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71742

CERTIFICATE OF DEATH.

11-00

D71742

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1109 Argyle ave ST.; 17 WARD)

2-FULL NAME Charles E. Pindle

(a) RESIDENCE. NO. 1109 Argyle av ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet Pindle

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Messenger

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edw Pindle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Bonfore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Catherine Patterson 1109 Argyle ave

15 Filed JAN 29 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1923, to Jan 27, 1923, that I last saw him alive on Jan 27, 1923, and that death occurred, on the date stated above, at 9.35 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Nephritis & Arteriosclerosis (duration) yrs. Don't Know mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. K. Fenwick M. D.

1/29 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft. Lincoln	Jan 30 1923

20 UNDERTAKER James A. Dewitt ADDRESS 1007 Eutaw

Boilerplate: IMPORTANT—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71743

CERTIFICATE OF DEATH.

139 D71743

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2446 Ellwing ST. 13 WARD)

2-FULL NAME. Allenia Dorsey

(a) RESIDENCE. No. 2446 Ellwing ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry J. Dorsey

6 DATE OF BIRTH (month, day, and year): Mch 19 1885

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
37	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Belair Md.

PARENTS

10 NAME OF FATHER: Joseph Booze

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Georgie Hill Jun

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mississippi

14 Informant: Georgie Booze (Address) 2446 Ellwing St.

15 JAN 29 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1923, to Jan. 27, 1923, that I last saw h[illegible] alive on Jan. 27, 1923, and that death occurred, on the date stated above, at 7.55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Anuria 2 days - Fibroid Lung or (duration) 3? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William N. Wright, M. D.

27. 1923 (Address) 1209 Presstman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Jan 31 1923

20 UNDERTAKER: James A. Dennis — ADDRESS 1303 Greenmount

INFORMATION CONCERNING THIS CASE, FOR USE IN COMPILING VITAL STATISTICS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of personsengaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, *6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Idem

Spec.—6-9-19—H. P. Co.—1000 Bks.

Worthington ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71744
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90

D71744
REGISTERED NO.

CITY OF BALTIMORE: (No. 235 N Schroeder St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Worthington

(a) RESIDENCE. No. 235 N Schroeder ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Thos Howard
(Address) 757 Dover St

15 DATE RECEIVED JAN 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 2 1922, to Jan 26 1923, that I last saw h... alive on Jan 26 1923, and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F Norwood, M. D.

Jan 27 1923 (Address) 939 W Fay Mt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 30 1923

20 UNDERTAKER Thos J Howard & Co ADDRESS 514 N Schroeder St

INSTRUCTIONS.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71745

CERTIFICATE OF DEATH.

131 D71745

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital St., 9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ellen McCann

(a) RESIDENCE NO. 1313 Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mr John McCann

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
about	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

137

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Edmond Dillon.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Edw. F. McCann
(Address) 1313 Valley St

15 Filed JAN 29 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-28 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1923, to Jan 28, 1923, that I last saw h[e] alive on Jan 27, 1923, and that death occurred, on the date stated above, at 9.20 a.m.

The CAUSE OF DEATH* was as follows:

Pyonephritis

(duration) yrs. 15 mos ds.

CONTRIBUTORY (Secondary) Kidney Stones

(duration) yrs. mos. ds.

18 Where was disease contracted - if not at place of death?

Did an operation precede death? Yes Date of 1-23-23

Was there an autopsy? No

What test confirmed diagnosis? Gross Path & Microscopic

(Signed) Edward Tyson, M. D.

1-28, 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery. DATE OF BURIAL Jan 31 1923

20 UNDERTAKER Henry Hoech & Son ADDRESS 1301 E Eager St

Spec.—1-10-21 M&T 1500 Bks.

D71746

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 74001

D71746

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2104 Moyer ST., 6 WARD)

2-FULL NAME Louis Jacks Archer

(a) RESIDENCE NO. 2104 Moyer ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Archer 1858

6 DATE OF BIRTH (month, day, and year): October 4 1858

7 AGE: Years 64 Months 0 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore County

PARENTS

10 NAME OF FATHER: Roland Archer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore County

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland county

14 Informant: Edna Patterson Clerk

(Address) 100 S Chapel St

15 Filed JAN 29 1923 19 ROBERT R. KRAETER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 24 1923 to Jan 25 1923

that I last saw him alive on Jan 25 1923

and that death occurred, on the date stated above, at 6.35 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. Heller M. D.

1/27. 1923 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Jan 28 1923

20 UNDERTAKER: Wendell J. Lippe — ADDRESS: 100 Wash

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71747

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D71747

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 16 WARD)

2-FULL NAME Charles Hoffman

(a) RESIDENCE No. 3407 E. Lombard St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Detroit, Mich.

PARENTS

10 NAME OF FATHER Lewis Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [redacted]Germany

14 Informant Municipal Hospital Records. (Address)

15 Filed JAN 29 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from January 17, 1923, to January 25, 1923, that I last saw him alive on January 25, 1923, and that death occurred, on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray Sputum

(Signed) Clyde McNeill, M. D.

1/25/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Trinity Cem — DATE OF BURIAL Jan 30th 1923

20 UNDERTAKER Wendel Hippleson — ADDRESS 373 Gannett

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71748

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

23 129

D71748

Registered No. C.....

City of BALTIMORE: (No. 904 Peach Alley. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Watson. (C).

50 -- 11 -- 12.

(Residence in Baltimore: No. 904 Peach Alley. St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored.	Single.

6-DATE OF BIRTH. February 5, 1872.
(Month) (Day) (Year)

7-AGE. 50 yrs. 11 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Louise Boardley. (C).
(Address) 904 Peach Alley.

15- Filed JAN 29 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 17. 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. M. Fenwick M. D.
(Coroner.)

Jan. 27, 1923. (Address) 1019 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
JOHNS HOPKINS HOSPITAL	19....
20-UNDERTAKER.	ADDRESS.
Commissioner Health.	JAN 29 1923

COPY TO THE MORGUE

Per. Wm. R. WOODALL

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71749

CERTIFICATE OF DEATH.

74-001

D71749

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD) —

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Smith

(a) RESIDENCE No. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Municipal Hospital Records. (Address)

15 Filed JAN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1923

17

I HEREBY CERTIFY, That I attended deceased from August 25, 1916 to January 25, 1923.

that I last saw him alive on January 25, 1923.

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde A. Brown, M. D.

1/25/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19 JAN 29 1923

20 UNDERTAKER: Commissioner Health.

ADDRESS

Reg. Wm. H. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

36

0926

Spec.—1-10-21—M&T—1500 Bks.

D71750

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00 D71750

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Franklin Square Hospital ST., 28 WARD)

2-FULL NAME Charles Jacob Weber Jr.

(a) RESIDENCE NO. 4203 Springdale Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma J. Weber

6 DATE OF BIRTH (month, day, and year) July 12 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Flour Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

045

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles J. Weber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Vienna Ansteid

12 MAIDEN NAME OF MOTHER Mary Hammer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs Emma J. Weber
(Address) 4203 Springdale Ave

15 JAN 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28th. 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Jan 28, 1923, that I last saw him alive on Jan 28, 1923, and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) Walter A Cap M. D.

1.28.1923 (Address) 2406 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon park Cemetery

DATE OF BURIAL Jan 30" 1923

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 W Balto St

Spec.—8-24-14—M. & T.—2000 Bks.

D71751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D71751

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 E. Eager ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C Ward.

(Residence in Baltimore: No. 512 E. Eager St.; 30 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~ Single (Write the word.)

6-DATE OF BIRTH, Aug. 25, 1871. (Month) (Day) (Year)

7-AGE, 51 yrs. 5 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Ward

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Ward

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Ward

(Address) 512 E Eager St

15- JAN 29 1923 Filed....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 27, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 24 1923, to Jan 27 1923, that I saw her alive on Jan 27 1923, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin K. Ballard M. D.

Jan 29, 1923 (Address) 162 W Mt Royal Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Cathedral Cem

DATE OF BURIAL, Jan 30, 1923

20-UNDERTAKER H C Mulefeld

ADDRESS 914 Hanover St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71752

CERTIFICATE OF DEATH

D71752

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

2-FULL NAME Mollie Rosenstock

(a) RESIDENCE NO. 1603 N. Caroline ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: Years 53; Months; Days; If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 309

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Ambrose Rosenstock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Rebecca Widefeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: University Hospital Records

(Address)

15 JAN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1923, to Jan 28, 1923, that I last saw her alive on Jan 28, 1923, and that death occurred, on the date stated above, at 4:20 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial nephritis

Hypertension

Cerebral hemorrhage

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. F. Jones, M. D.

1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Govans — DATE OF BURIAL: Jan 31 1923

20 UNDERTAKER: J. C. Widefeld — ADDRESS: 914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71753

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71753

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1729 N. Caroline ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Keelan Hall

(a) RESIDENCE NO. 1729 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 75 yrs. -- mos. -- ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse K. Hall

6 DATE OF BIRTH (month, day, and year) Aug. 17, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ----------

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John H. Hall

(Address) 2335 Harford Ave.

15 JAN 29 1923 ROBERT K. KNAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 19-22 to Jan 27, 1923.

that I last saw h alive on Jan 26, 1923

and that death occurred, on the date stated above, at 2.15-P m.

The CAUSE OF DEATH* was as follows:

Carcinoma liver

1 Dom Rum (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) / month asthenia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? nr Date of

Was there an autopsy? nr

What test confirmed diagnosis? —

(Signed) W. J. Riley M. D.

, 19 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 1/30, 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71754 D71754

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 4330 Orchard ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A. Johnson

(Residence in Baltimore: No. 4330 Orchard St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Aug. 6th, 1884 (Month) (Day) (Year)

7-AGE, 38 yrs. 5 mos. 21 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE, (State or Country), Baltimore, City

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliz. Johnson

(Address) 4330 Orchard St.

15- JAN 29 1923

Robert F. Harrison, M.D. Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 27th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 20th, 1923 to Jan. 27th, 1923, that I saw h[illegible] alive on Jan. 24th, 1923, and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(Duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) ... yrs. ... mos. ... ds.

(Signed) [illegible] M. D.

[illegible], 192[illegible] (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loud Auburn Cem. DATE OF BURIAL, 1-30, 1923

20-UNDERTAKER Geo. F. A. Gibson ADDRESS 613 Lanvale

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D71755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 D71755

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph Hospital; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Fritziges

(Residence in Baltimore: No 228 N. Port St St.: yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED,~~ OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb 2, 1871
(Month) (Day) (Year)

7-AGE, 51 yrs. 11 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Fireman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Fred Fritzigs

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Kate Santorious

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Susan

(Address) 228 N. Port St.

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

JAN 29 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jany 28, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto truck accident Truck
passed over abdomen
Abdominal Hemorrhage —

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Investigation to be held

..... (Duration).....yrs.....mos.....ds.

(Signed) J S Mc Allen M. D.
(Coroner.)

1-29 1923 (Address) 508 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, June 30 1923

20-UNDERTAKER Jas C. Miller ADDRESS 2334 Jeffers

23.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should also CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WARNING—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71756 D71756

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital (St.) 17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma C. Heck

(a) RESIDENCE NO. 830 Harlem ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F | 4 COLOR OR RACE: W | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan

7 AGE: Years 38 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0 10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Heck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Hosp. Records (Address)

15 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

JAN 29 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-28-1923

17 I HEREBY CERTIFY, That I attended deceased from 1-13-, 1923, to 1-28, 1923

that I last saw h alive on Jan 28, 1923

and that death occurred, on the date stated above, at 11:25 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Clyde Reid M. D.

1/29, 1923 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Jan 31 1923

20 UNDERTAKER: W. M. Routson — ADDRESS: 2236 N Monta

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71757

CERTIFICATE OF DEATH.

11-001

D71757

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 Greenmount Ave 10 WARD)

2-FULL NAME Jacob Vandaniker

(a) RESIDENCE. No. 722 Greenmount Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Vandaniker

6 DATE OF BIRTH (month, day, and year) Jan 14, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Polisher

(b) General nature of industry, business, or establishment in which employed (or employer) Low & Front Sts

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Lulu Jastadt

(Address) 1516 Eager

15 1923 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1923, to Jan 27, 1923, that I last saw him alive on Jan 27, 1923, and that death occurred, on the date stated above, at 6 00 m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

Influenza Flu ?

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? 722 Greenmount Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James W Benton, M. D.

1/27 1923 (Address) 700 E Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	1923
20 UNDERTAKER	ADDRESS
Edmund W Conklin	24 E Eager

29 1923

Burial Permit Issued

L.—WRITE PLAINLY, WITH INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71758

D71758

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2689 St Benedict WARD 20)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clement J Stromberg

(a) RESIDENCE NO. 2689 St Benedict ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mollie Stromberg

6 DATE OF BIRTH (month, day, and year): May 5 1850

7 AGE — Years: 72 — Months: 8 — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardener

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wm Stromberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina Linder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs H Stromberg 2689 St Benedict St

15 Filed: 29 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 25. 1923. to Jan 27. 1923.

that I last saw him alive on Jan 27. 1923.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilitation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry Glassman M. D.

Jan 28 1923 (Address) 2687 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 1/31/23

20 UNDERTAKER: Geo A Farley Sons — ADDRESS: Lafayette

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71759

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

D71759

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1302 Morling Ave. St.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Bamber

(Residence in Baltimore: No. 1302 Morling Ave. 34 yrs.— mos.— ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Jan. 16, 1838
(Month) (Day) (Year)

7-AGE. 85 yrs. — mos. 12 ds.

If LESS than 1 day, ...hrs. or....mts.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country) Germany

PARENTS.

10-NAME OF FATHER Charles Hettis

11-BIRTHPLACE OF FATHER (State or Country) Germany

12-MAIDEN NAME OF MOTHER Margaret

13-BIRTHPLACE OF MOTHER (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. E. Redding

(Address) 1302 Morling Ave.

15-

Filed Robert P. Harrison, Registrar.

1 29 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 28, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest or Inquiry.) thereon and from the evidence obtained by said (Inquest or Inquiry.) aforesaid find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis

Old Age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

Jan 29 1923 (Address) 1092 Rob[illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Mary's (Hampden)

DATE OF BURIAL, Jan 30, 1923

20-UNDERTAKER Horace F. Burgee

ADDRESS 363 Hollins Rd.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D71760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71760

CERTIFICATE OF DEATH.

99-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Light St. ST. 24 WARD)

2-FULL NAME Thomas H. League

(a) RESIDENCE NO. 1615 Light St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara V League

6 DATE OF BIRTH (month, day, and year) March 14 1848

7 AGE Years 74 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shop Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thos. C. League

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Durant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clara V League (Address) 1615 Light St.

15 Filed , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23 1923, to Jan 27 1923, that I last saw him alive on Jan 27 1923, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion

Pneumonia Congestion

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) A. Hurd Jr. M. D.

19 (Address) 1210 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 1/30 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Nor

Filed 2 9 1923

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71761

D71761

CERTIFICATE OF DEATH.

91-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1836 N. Hafford ST., 9 WARD)

2-FULL NAME Rosalie Ruggles.

(a) RESIDENCE NO. 1836 N. Hafford ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 60 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late William Ruggles.

6 DATE OF BIRTH (month, day, and year) Sept. 9. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	four	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Carroll Co.
(State or country)

PARENTS

10 NAME OF FATHER David Coffersmith

11 BIRTHPLACE OF FATHER (city or town) Carroll Co
(State or country)

12 MAIDEN NAME OF MOTHER Rosalie Coffersmith

13 BIRTHPLACE OF MOTHER (city or town) Carroll County.
(State or country)

14 Informant Charles Wyatt
(Address) 536 N. Hafford

15 Filed ..... 19 .....

Robert P. Harrison,
Burial Permit Clerk.
Registrar

N 29 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1923, to Jan 28 1923, that I last saw her alive on Jan - 26 1923 and that death occurred, on the date stated above, at 1 a - m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis -
Asthma

(duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) E. Dall Hall, M. D.

Jan 29 1923 (Address) 1617 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery.

DATE OF BURIAL 1 31 1923

20 UNDERTAKER George J. Roche

ADDRESS 1731 Harford

Spec.—1-10 21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71762 D71762

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 N. West ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvira E. Wright

(a) RESIDENCE NO. 203 N. West ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Wright

6 DATE OF BIRTH (month, day, and year) Nov 12th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ellicott City

PARENTS

10 NAME OF FATHER Wells Murdock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann S. Cline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md

14 Informant Mrs Ida M. Mack

(Address) 2 Lexington Street 2nd St.

15 Filed ..., 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/31, 1923, to 1-27, 1923

that I last saw her alive on 1-27, 1923

and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

(a) Bronchs Pneumonia

(duration) yrs. mos 7 ds

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) James A. Brown, M. D.

, 19 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet — DATE OF BURIAL Jan 30th 1923

20 UNDERTAKER E. Schloman & Son — ADDRESS 1024 Hanover St

JAN 29 1923

WARNING—RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71763

CERTIFICATE OF DEATH.

D71763

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 S. Collington ave ST. 1 WARD)

2-FULL NAME Catherine Zantizi

(a) RESIDENCE NO. 306 S. Collington ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Zantizi

6 DATE OF BIRTH (month, day, and year) February 22 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Maryland (State or country)

PARENTS

10 NAME OF FATHER Daniel Anderson

11 BIRTHPLACE OF FATHER (city or town) Baltimore Maryland (State or country)

12 MAIDEN NAME OF MOTHER Mary McGinty

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Maryland (State or country)

14 Informant Nicholas Zantizi

(Address) 306 S. Collington ave

15 Filed Jan 29 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Jan 27, 1923.

that I last saw h— alive on Jan 27, 1923;

and that death occurred, on the date stated above, at A m.

The CAUSE OF DEATH* was as follows:

Intussusception (Pathology)

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Jan 29, 1923 (Address) #148 Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Jan 31 1923

20 UNDERTAKER Wendell Reifsnider

ADDRESS 137 S. Mount

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N 29 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71764 D71764

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 807 N Howard ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter C. Ringsdorf

(a) RESIDENCE. No. 807 N. Howard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or ~~WIFE~~ of) Olga E. Ringsdorf

6 DATE OF BIRTH (month, day, and year) Dec 16, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager Steam Ship Co

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jacob Ringsdorf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Bartels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Olga E. Ringsdorf

(Address) 807 N Howard St

15 Filed JAN 29 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to Jan 29, 1923

that I last saw h[illegible] alive on Jan 28, 19..,

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. T. Grahame, M. D.

JAN 29 1923, 19.. (Address) 1335 Eighth St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park DATE OF BURIAL FEB 1 1923

20 UNDERTAKER Geo W Little ADDRESS 2700 EDMONDSON AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 29 1923

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71765

CERTIFICATE OF DEATH.

91-002

D71765

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 Eutaw Place ST.: 14 WARD)

2-FULL NAME Frank K. Bowers

(a) RESIDENCE. No. 2006 Eutaw Place ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or ~~divorced~~ HUSBAND of (or ~~WIFE of~~) Virginia R. Bowers

6 DATE OF BIRTH (month, day, and year) June 1 1855

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
67	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Cigar

(b) General nature of industry, business, or establishment in which employed (or employer): Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Wm Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Anna E. Noble

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Richard Kutzleb (Address) 2701 Lemmon Ave

15 Filed JAN 29 1923 Robert P. Harriman, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 28 1923

17 I HEREBY CERTIFY, That I attended deceased from January, 1922, to Jan. 28, 1923, that I last saw h— alive on Jan 28, 1923, and that death occurred, on the date stated above, at 5.17 P. m.

The CAUSE OF DEATH* was as follows:

Arteri-o clerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) ocdem of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Fred Leitz, M. D.

JAN 29 1923 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: JAN 31 1923

20 UNDERTAKER: Geo W Little

ADDRESS 2700 EDMONDSON AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 29 1923

Mary A. Schaffer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71766

CERTIFICATE OF DEATH.

1/4-001

D71766

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE (No.) 1669 W Fayette St. (Ward) 15

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary A. Schaffer

(Residence in Baltimore: No. 16 W. Fayette St.) (If not in Baltimore, give usual residence.) (If non-resident or transient, write "Non-Resident" or "Transient" and give State.) (Inserted by Registrar.)

(If under 1 day, ... hrs. or ..... min.) (If under 1 year, ... mos. ..... ds.)

77 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX: F

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word): Widowed

6 DATE OF BIRTH: ....., 1856
(Month) (Day) (Year)

7 AGE: 77 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9 BIRTHPLACE (State or Country): Baltimore

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or Country): Germany

12 MAIDEN NAME OF MOTHER: Mary Smith

13 BIRTHPLACE OF MOTHER (State or Country): Germany

PARENTS.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. L. Knight

(Address) 1669 W Fayette St.

15 JAN 29 1923

Robert R. Harrison,
Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH: Jan 27, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq. (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Mousa M. D.
(Coroner.)

Jan 27, 1923 (Address) 3692 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Jan 30, 1923

UNDERTAKER: Martin Haley & Son

ADDRESS: 1827 N North Ave

Spec.—1-10-21—M&T—1500 Bks.

D71767

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71767

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1225 Cloverdale Road WARD 13)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Wilhide

(a) RESIDENCE NO. 1225 Cloverdale Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. B. Wilhide

6 DATE OF BIRTH (month, day, and year) Jan 7 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Benjamin Burhorst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Eliz. Burkholder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John L. B. Wilhide 1225 Cloverdale Rd

15 Filed JAN 29 1923, 19 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1923

I HEREBY CERTIFY, That I attended deceased from Jan 17 1923, to Jan 27 1923, that I last saw h[illegible] alive on Jan 27 1923, and that death occurred, on the date stated above, at 5-50 8 m.

The CAUSE OF DEATH* was as follows:

Uremia — Coma

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Diabetes Mellitus

yrs 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Blood Pressure

(Signed) Henry C. Flynn M. D.

(Address) 3640 Roland Ave

Jan 27 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Jan 30 1923

20 UNDERTAKER W. J. Pentz & Sons

ADDRESS North & Preston Sts

037

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DO NOT WRITE IN THIS SPACE—RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71768

CERTIFICATE OF DEATH.

D71768

1-PLACE OF DEATH

REGISTERED NO. C 44

CITY OF BALTIMORE: (No. 2507 Madison ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth D. Bailey

(Residence in Baltimore: No. 2507 Madison ave; 63 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, May 11, 1859 (Month) (Day) (Year)

7-AGE, 63 yrs. 8 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... No paid occupation
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, A. N. Dietz

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eliz. Wurth

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliz. D. Bailey (Stepdaughter)

(Address) 2507 Madison ave

15-

Filed JAN 29 1923 Robt. P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 27, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 11 1923, to Jan. 27 1923, that I saw her alive on Jan. 27 1923, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of stomach

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. F. Stemwell M. D.

Jan. 27, 1923 (Address) 2236 Madison ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem

DATE OF BURIAL, Feb. 2 1923

20-UNDERTAKER Wm. J. McKnew & Son

ADDRESS North & Pa

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71769

CERTIFICATE OF DEATH.

100-001 D71769

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

2-FULL NAME Ida Lovell Morrow

(a) RESIDENCE NO. 3917 Kate Av. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hugh S. Morrow

6 DATE OF BIRTH (month, day, and year) Apr. 17, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Olivia M. Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records.

(Address) Robert P. Harrison.

JAN 29 1923 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1923, to Jan. 29, 1923, that I last saw her alive on Jan 29, 1923, and that death occurred, on the date stated above, at 4:25 a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms & Signs.

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Jan 31 1923

20 UNDERTAKER W. J. Tucker & Co ADDRESS North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71770

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14-001

D71770

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 S. Kenwood Av ST., | WARD)

2-FULL NAME Catherine E. Fiffincott

(a) RESIDENCE NO. 635 S. Kenwood Av ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Thos. C. Fiffincott

6 DATE OF BIRTH (month, day, and year): Mar 4-63

7 AGE — Years: 59 — Months: 10 — Days: 23 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer: 037

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Nicholas Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliza Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary J. Thamert

(Address) 635 S. Kenwood

15 JAN 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 25th, 1923, to Jany 27th, 1923, that I last saw her alive on Jany 27th, 1923, and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. H. Fouke M. D.

1/29/1923 (Address) 1011 N. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk

DATE OF BURIAL: 1/30 1923

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans

Spec.—1-10-21—M&T—1500 Bks.

D71771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D71771

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 Scott St ST. 21 WARD)

2-FULL NAME Joseph H Linnenbom

(a) RESIDENCE NO. 803 Scott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

* Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Linnenbom

6 DATE OF BIRTH (month, day, and year): Oct 16 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer): City 1886

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't know

12 MAIDEN NAME OF MOTHER: " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Wm A. Clubb

(Address) 803 Scott St.

15 Filed JAN 30 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-28 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25 1923 to Jan 28 1923

that I last saw him alive on Jan 28 1923

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Solar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Morley Stoag M. D.

1/29 1923 (Address) 729 Wash. Blvd

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Jan 31, 1923

20 UNDERTAKER: Wm. Cook

ADDRESS: 502 E North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D71772

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D71772

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2303 Belair Rd ST.: 8 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry F. Hannan

(Residence in Baltimore: No. 2303 Belair Rd St.: 18 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6-DATE OF BIRTH: May 19, 1870 (Month) (Day) (Year)

7-AGE: 52 yrs. 6 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Grocery Worker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE (State or country): Cambridge Mass

PARENTS

10-NAME OF FATHER: unknown

11-BIRTHPLACE OF FATHER (State or country): unknown

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (State or country): unknown

14-I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary Hardesty

(Address) 2303 Belair Rd

15

Filed JAN 30 1923 ROBERT R. KRAUTER, REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: January 28, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 26, 1923, to, January 28 1923, that I saw him alive on January 28, 1923, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) P H Toller M. D.

1-28, 1923 (Address) 508 E Northern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge — DATE OF BURIAL: January 30, 1923

20-UNDERTAKER: Robt Johnson Inc — ADDRESS: 14 Bond

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71773 HEALTH DEPARTMENT—CITY OF BALTIMORE D71773

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

2-FULL NAME Elizabeth Contee

(a) RESIDENCE No. 612 Hubbards Alley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 28-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Contee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elena Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Louisiana

14 Informant Records (Address)

15 Filed JAN 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from January 23. 1923. to January 28 1923. that I last saw her alive on January 28, 1923, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia and Pertussis

(duration) 0 yrs. 0 mos 16 ds.

CONTRIBUTORY (Secondary) Otitis media, suppurative

(duration) 0 yrs. 0 mos. 6 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Non

(Signed) Horton Casparis M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Jan 30 1923

20 UNDERTAKER Mrs Robert A Elliott — ADDRESS 1125 Pearlland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Calvert

Spec.—1-10-21—M&T—1500 Bks.

D71774 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 D71774

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hosp. REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No.) Fayette & Calhoun ST., 19 WARD)

2-FULL NAME Chas Calvert.

(a) RESIDENCE NO. ~~None~~ 526 Addison alley ST./ WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O&D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dont Know

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Solomon Calvert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Martha Blake
(Address) 916 N. Carey st.

15 JAN 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 19 23

17

I HEREBY CERTIFY, That I attended deceased from Jan 26 , 19 23 , to Jan 27 , 19 23.

that I last saw him alive on Jan 27 , 19 23

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Suspected Cerebral Syphilis
Neuritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Apoplexy.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) R. A. Harmon , M. D.

, 19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL Jan 30 19 23

20 UNDERTAKER A. Jones ADDRESS 111 S. Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71775

CERTIFICATE OF DEATH.

161-001

D71775

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1636 N. Bentalou St ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME no name. Infant Preston

(a) RESIDENCE. No. 1636 N. Bentalou ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-28-23.

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or 14 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) — dead

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Edgar Allen Preston.

11 BIRTHPLACE OF FATHER (city or town) Trenton (State or country) New Jersey.

12 MAIDEN NAME OF MOTHER Florence Augusta Falkinburg

13 BIRTHPLACE OF MOTHER (city or town) Ostonville (State or country) New Jersey.

14 Informant Florence Augusta Preston
(Address) 1606 N. Bentalou St.

15 Filed . 19 JAN 30 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-28- 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-28-, 1923, to 1-28-, 1923, that I last saw h[illegible] alive on 1-28-, 1923, and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.
(5 month foetus)

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chester Riland. M. D.

1-28, 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	JAN 29 1923

20 UNDERTAKER

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71776

CERTIFICATE OF DEATH.

91-002 1823 D71776

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Myrtle Ave. ST. ~~14~~ WARD)

2-FULL NAME Mary Rose Flint

(a) RESIDENCE. No. 1404 Myrtle Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James W. Flint

6 DATE OF BIRTH (month, day, and year) Nov 18 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Nathaniel Groome.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elizabeth Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mary Rose Flint
(Address) 1404 Myrtle Ave.

15 JAN 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1922, to Jan. 26, 1923, that I last saw her alive on Jan. 26, 1923, and that death occurred, on the date stated above, at 8.10 a.m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis
with Hypostatic Complications

(duration) about yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Infirmities of age.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Gen'l Clinical Symptoms

(Signed) Wm. M. Bannebaker, M. D.

, 19 (Address) 209 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral DATE OF BURIAL Jan 31 1923

20 UNDERTAKER Thomas C. Wright ADDRESS 1364 Mary

Spec.—1-10-21—M&T—1500 Blks.

D71777

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71777

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Romeo

(a) RESIDENCE NO. 505 Appel Court. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Indies

PARENTS

10 NAME OF FATHER: James Romeo

11 BIRTHPLACE OF FATHER (city or town) (State or country): West Indies

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Indies

14 Informant: Municipal Hospital Records.

(Address)

15 Filed JAN 30 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 27 1923

17

I HEREBY CERTIFY, That I attended deceased from January 26, 1923, to January 27, 1923,

that I last saw him alive on January 27, 1923,

and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Refused

What test confirmed diagnosis?

(Signed) [signature] M. D.

1/29/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: Jan 30 1923

20 UNDERTAKER: John E Henderson — ADDRESS 1502 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71778

CERTIFICATE OF DEATH.

11-001 D71778

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1635 N. North Ave

CITY OF BALTIMORE: (No 1635 W. N. Ave ST., 15 WARD)

2-FULL NAME Geo. Hotter

(a) RESIDENCE NO. 1635 W. N Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) June 29 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman merchandise 066

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo Hotter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Pfeiffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward Hotter

(Address) 1635 W North Ave

15 Filed JAN 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1923 to Jan 29, 1923.

that I last saw him alive on Jan 29, 1923.

and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos 3 ds.

CONTRIBUTORY (Secondary) Influenza —

(duration) 0 yrs. 0 mos. 10 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R B Tenley M. D.

Jan 30, 1923 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorden Park DATE OF BURIAL Feb 1 1923

20 UNDERTAKER Josiah Sapper ADDRESS 1600 W North Ave

Spec.—8-24-14—M. & T.—2000 Blks.

D71779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160

REGISTERED NO. D71779

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 W. Lombard ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Lewis Kroder Jr

(Residence in Baltimore: No. 1023 W Lombard St.; ....yrs., ...mos. 1½ ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOW(ER) OR DIVORCED~~ (Write the word.) Single

6-DATE OF BIRTH, Jan (Month) 27 (Day), 1923 (Year)

7-AGE, ...yrs. ....mos. 1½ ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~Child~~
(b) General nature of industry, business, or establishment in which employed (or employer) Child

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Edw. L. Kroder

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Eve A. Grace

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw L Kroder

(Address) 1323 W. Lombard St

15- JAN 30 1923

Filed ....., 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 27 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 27 1923, to Jan 29 1923, that I saw h[illegible] alive on Jan 2[illegible] 1923, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Respiratory paralysis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Edwin K. Ballard M. D.

Jan 29, 1923 (Address) 1622 Mt Royal

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Jan 30, 191...

20-UNDERTAKER Josiah Dyer Hearse and Auto Co.

ADDRESS

Remarks Normal delivery. After birth, this child did not breathe. Full artificial respiration had been practiced for 1¼ hr.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scptichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis.*	*Peritonitis.*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec. 1-10-21 M&T 1500 Blks.

D71780

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71780

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alverta Holt

(a) RESIDENCE No. 1635 Division st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Francis Holt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M.T.H.

15 Filed JAN 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1922, to Jan. 27, 1923,

that I last saw her alive on Jan. 27, 1923,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Dadaglieles M. D.

1-27-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Helena Ann

DATE OF BURIAL 1-31-1923

20 UNDERTAKER Daniel Easton.

ADDRESS 516 Ba

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DO NOT WRITE IN THIS SPACE—RESERVED FOR BINDING

8spec.—1-10-21 M&T 1500 Blks.

D71781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D71781

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Edwards

(a) RESIDENCE NO. 205 W. Montgomery st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Edwards

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Richard Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Alice Padic

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) M.T.H.

15 Filed JAN 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1922, to Jan. 27, 1923, that I last saw him alive on Jan. 27, 1923, and that death occurred, on the date stated above, at 7.05 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) Jeremiah L. Dalaglacca M. D.

1-27-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 1-30 1923

20 UNDERTAKER Daniel Easter

ADDRESS 916 Pa Ave

Spec.—1-10-21—M&T—1500 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71782

CERTIFICATE OF DEATH.

101-001 D71782

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Dabarowski

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Sophia Kasky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Municipal Hospital Records.

15 Filed JAN 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 27 1923

17

I HEREBY CERTIFY, That I attended deceased from January 15, 1923 to January 27, 1923, that I last saw him alive on January 27, 1923, and that death occurred, on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Paralitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Snell, M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery — DATE OF BURIAL: 1/30. 1923

20 UNDERTAKER: Mrs M. Fenk — ADDRESS: 1737 W. Pratt St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71783 X74-001 D71783

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1100 E Eager ST., 10 WARD)

2-FULL NAME Agnes Pillore

(a) RESIDENCE NO. 1100 E Eager ST., 10 WARD Richmond Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 3 mos. — ds. How long in U. S., if of foreign birth? — yrs. 3 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Pillore

6 DATE OF BIRTH (month, day, and year) February 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Ferraro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs Louis Pillore

(Address) 616 E Eager St

15 FILED JAN 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1923, to Jan. 29. 1923, that I last saw her alive on Jan. 29. 1923, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. one hour.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) E. N. Lobeck, M. D.

, 19 (Address) 1001 Virginia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan 31 1923
20 UNDERTAKER	ADDRESS
Henry Storck Son	1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71784

CERTIFICATE OF DEATH.

88 D71784

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3013 Windsor Av ST., 15 WARD)

2-FULL NAME Roz Weinstein

(a) RESIDENCE NO. 3013 Windsor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Weinstein

6 DATE OF BIRTH (month, day, and year) May 31 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Hillel Ashman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Katie Caplan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Baltimore

15 Filed JAN 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-29 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1922 to Jan 29 1923, that I last saw h[illegible] alive on Jan 29 1923, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Septic endocarditis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles F Bloke M. D.

1-29 1923 (Address) 20 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrem Rosedale

DATE OF BURIAL 1/30 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause Unknown

D71785

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71785

99-002

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 Merryman St. WARD 17)

2-FULL NAME Anna Winston

(a) RESIDENCE No. 402 Merryman st WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A Winston

6 DATE OF BIRTH (month, day, and year) Sept 6 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) — — 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Caroline Co Va Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Mary Simms

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant John Winston

(Address) 402 Merryman ave

15 FILED JAN 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1923, to Jan 26, 1923, that I last saw h.. alive on Jan 26, 1923, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Asthma and Heart Failure

OV OS

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Senile Exhaustion & Cold (duration) ? yrs. ? mos. 10 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Med L Hall, M. D.

, 19 (Address) 426 E 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 28 1923
20 UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	1725 Eastlander

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Bronchitis,
not T. B.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(See Letter attached)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71786

CERTIFICATE OF DEATH.

1924 D71786

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.)

No. 867 Hanlem ST. 17 WARD)

2-FULL NAME James W Smith

(a) RESIDENCE. No. 867 Harlem ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Public Schools

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Stevensville Va.

PARENTS

10 NAME OF FATHER Richmond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va "

12 MAIDEN NAME OF MOTHER Richmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va "

14 Informant Mrs Jas W Smith (Address) 867 Harlem Ave

15 Filed JAN 30 1923 Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1923, to Jan 28, 1923, that I last saw h alive on Jan 28, 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bright's Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. F. Mellanie, M. D.

, 19 (Address) 1303 W. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 1/30/23

20 UNDERTAKER Samuel Friedlander — ADDRESS 578 N Bridle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REG. NO. 2917

DR. JAMES A. MELVIN
1303 W. NORTH AVENUE
PHONE. MADISON 6352

OFFICE HOURS:
8 TO 10 A. M.
2 TO 4 P. M.
6 TO 8 P. M.

DATE

PATIENT'S NAME ADDRESS

R Health Department.
James W Smith
Was born 1820 — now 5'3 years old
J. A. Melvin

Balto July 1 1923

ROBINSON'S DRUG STORE
2139-41 PENNSYLVANIA AVE.
BALTIMORE, MARYLAND.

FULL NAME M D

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.
[Approved by U. S. Census and American Public Health Asso.]

port ... typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges,* peritoneum, etc., *Carcinoma, Sarcoma,* etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles;*

REG. NO. 2917

DR. JAMES A. MELVIN
1303 W. NORTH AVENUE
PHONE. MADISON 6352

OFFICE HOURS
8 TO 10 A. M.
2 TO 4 P. M.
6 TO 8 P. M.

DATE

PATIENT'S NAME ADDRESS

R Dr C Hompson Jones.
Kindly
Change the age of James W Smith
from 65 years & 5/3 years and
this will be your authority for it.
Mrs James A Melvin

July 1923

ROBINSON'S DRUG STORE
2139-41 PENNSYLVANIA AVE.
BALTIMORE, MARYLAND.

FULL NAME M D

71786.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71787

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71787

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1041 N. Mount St. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Palmer

(a) RESIDENCE. NO. 1041 N. Mount ST., WARD.

(Usual place of abode) dont

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Tania Palmer

6 DATE OF BIRTH (month, day, and year) ~1876 Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) General housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Patrick Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Wm. Gordon 317 N. Carlton St.

15 Filed JAN 30 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1922, to Jan 27, 1923, that I last saw h~~e~~r alive on Jan. 27, 1923, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 30 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thos. T. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Jan 30 1923

20 UNDERTAKER Samuel Schneider

ADDRESS 578 N Eutaw

IMPORTANT: WRITE LEGIBLY. USE INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history —
Appeared to be older.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D71788

CERTIFICATE OF DEATH

113

D71788

REGISTERED No. C .....

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1330 Etting ST. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Isaac Banke

(Residence in Baltimore: No. 1330 Etting St.; yrs. 6 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: July (Month) 11 (Day), 1922 (Year)

7 AGE: yrs. 6 mos. 18 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): None

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Richard Banke

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma Beale

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Banke (Mother)

(Address) 1330 Etting St.

15 Filed JAN 30 1923 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 1 (Month) 29 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1923 to Jan 28 1923 that I saw h[illegible] alive on Jan 27 1923 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Convulsions with Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds

Contributory (SECONDARY) Otitis Media 3

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) I. S. Hartman M. D.

Jan 30, 1923 (Address) 1202 S Hull St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Jan. 30, 1923

20 UNDERTAKER: Jno. W. Johnson

ADDRESS 1234 Etting St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71789

CERTIFICATE OF DEATH.

101-001 D71789

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 Church Ave ST., 25 WARD)

2-FULL NAME Amelia Johanna Salzmann

(a) RESIDENCE NO. 125 Church ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Salzmann

6 DATE OF BIRTH (month, day, and year) June 20-1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
68	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) ... (State or country) Austria

PARENTS

10 NAME OF FATHER Louis Rossel

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Sterkebeck

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Austria

14 Informant Mrs. Leonard Rossabella (Address) 125 Church ave.

15 FILED JAN 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1923, to Jan 28, 1923, that I last saw h-e alive on Jan 28, 1923, and that death occurred, on the date stated above, at 9 45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) James Brown, M. D.

1/28 1923 (Address) 1837 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Jan 30 1923

20 UNDERTAKER John Ulrich ADDRESS 2008 Pleasant

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

TYPEWRITER, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71790

CERTIFICATE OF DEATH.

31 D71790

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1625 Madison Ave ST., 14th WARD)

2-FULL NAME Harry Egerton Pontier

(a) RESIDENCE NO. 1625 Madison Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Georgianna Pontier

6 DATE OF BIRTH (month, day, and year) Aug 17 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Freight Representative C. B. & O. R.R.

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Col. Edw F. Pontier

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md

12 MAIDEN NAME OF MOTHER Mary R Hogg

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) md.

14 Informant Miss Cora A Pontier NRP.
(Address) 1625 Madison Ave

15 Filed JAN 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1921 to Jan 27 1923.

that I last saw him alive on Jan 27 1923 and that death occurred, on the date stated above, at 8.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) do not know yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) do not know yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R Pleuster M. D.

, 19 (Address) Wyllwood Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 1/30 1923

20 UNDERTAKER Henry W. Meaux & Son

ADDRESS 805 N. Calvert St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71791

D71791

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3023 St. Paul St. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred J. Carr

(a) RESIDENCE NO. 3023 St. Paul ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Young

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER James E. Carr

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Amanda Wright

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Mrs. Grace Young
(Address) 3023 St. Paul St.

15 Filed JAN 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 19, 1923, to Jan 29, 1923, that I last saw him alive on Jan 29, 1923 and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jay F. Phillips M. D.

Jan 30 1923 (Address) 1929 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 1/31 1923

20 UNDERTAKER: Henry W. Mears & Son 805

ADDRESS: N. Calvert

INSTRUCTIONS—TYPEWRITER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71792

D71792

164

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 919 N. Broadway ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cemid Kahik

(a) RESIDENCE NO. 919 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Kahik

6 DATE OF BIRTH (month, day, and year) 1830

7 AGE: Years 90; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Louis

(Address) 1439 E Baltimore

15 Filed JAN 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923 to Jan 30, 1923, that I last saw h[illegible] alive on Jan 29, 1923, and that death occurred, on the date stated above, at 8:30 a m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) general debility

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Jan 31, 1923 (Address) 1114 E. Bmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Nursing Assn

DATE OF BURIAL: 1/30 1923

20 UNDERTAKER: Jack Louis

ADDRESS 1439 E Balt

INSTRUCTIONS.—THIS CERTIFICATE, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 117 D71793

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospital ST., Keyley 11 WARD)

2-FULL NAME Mrs Jane Keyley

(a) RESIDENCE No. Rock Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Lucian Keyley

6 DATE OF BIRTH (month, day, and year) Sept 26 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Wytheville
(State or country) Virginia

PARENTS

10 NAME OF FATHER Jacob Lalron

11 BIRTHPLACE OF FATHER (city or town) Wytheville
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Nancy Daught

13 BIRTHPLACE OF MOTHER (city or town) Wytheville
(State or country) Va

14 Informant George F Keyley Husband
(Address) R.D. Rockal Md

Filed JAN 30 1923, 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/29/23 19

17 I HEREBY CERTIFY, That I attended deceased from 1/23/23, 19.., to 1/29/23, 19.., that I last saw h alive on 1/29/23, 19.., and that death occurred, on the date stated above, at 7 00 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Appendicitis & Chronic Emphysema

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 1/24/23

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings & Microscopic

(Signed) Jno A Dempsey, M. D.

, 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel Church Cem.

DATE OF BURIAL Feb 1 1923

20 UNDERTAKER E J Kurtz & Son

ADDRESS Jarrettsville Md

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71794

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001

D71794

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 Marshall ST., 23 WARD)

2-FULL NAME Fredricka Gunther

(a) RESIDENCE NO. 1705 Marshall ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Gunther

6 DATE OF BIRTH (month, day, and year) Apr 29 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	67	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carl Mundt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Anna A Gardner
(Address) 35 E Fort Ave

15 Filed JAN 30 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1923, to Jan 30, 1923, that I last saw her alive on Jan 29, 1923 and that death occurred, on the date stated above, at 7 a m

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

about 3 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Influenza

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm Engler, M. D.

1/30 1923 (Address) 1319 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Hill Cemetery DATE OF BURIAL 2/1 1923

20 UNDERTAKER William Cook ADDRESS 502 E North

JAN 30 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71795 D71795

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Smith

(a) RESIDENCE NO. 762 Mulberry St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
40 (?)	--		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Peggy Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records. (Address)

15 Filed 1/29/1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan/ 28 1923

17 I HEREBY CERTIFY, That I attended deceased from January 24, 1923, to January 28, 1923, that I last saw him alive on January 28, 1923, and that death occurred, on the date stated above, at 6:50 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 wk ds.

CONTRIBUTORY (Secondary)* Hemiplegia — Syphilis — Arteriosclerosis — Strokes (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. A. Mackay M. D.

1/29/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Jan. 31 1923

20 UNDERTAKER Easton Sons & Elliott ADDRESS City

INFORMATION, WITH LEADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

30 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71796

CERTIFICATE OF DEATH.

89

D71796

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas C. Wheatley

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years	Months	Days	If LESS than 1 day: ....hrs. or ....min.
61	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) 170

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed ....., 19 Robert F. Harrison, Burial Permit Clerk. Registrar

JAN 30 1923

0080

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 22, 19 20 to January 25, 19 23.

that I last saw him alive on January 25, 19 23.

and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

1/26/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS JAN 30 1923

Per. Wm. E. Woodall

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D71797 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D71797

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Courtney

(a) RESIDENCE NO. 1124 Sarah Ann st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Frank Courtney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) H.T.H.

15 JAN 30 1923 Albert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25, 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1922 to Jan. 25, 1923, that I last saw her alive on Jan. 25, 1923, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Blakeslee M. D.

1-25-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS JAN 30 1923

JAN 30 1923

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71798

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Maryland General Hosp. ST., 16 WARD)

2-FULL NAME Bertie H. Davis

(a) RESIDENCE NO. 1416 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Fordsville Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Sarah Ann Lyon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Miss Vivian Mitchell

(Address) 1416 Poplar Grove St

15 Filed 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29th 1923

17 I HEREBY CERTIFY, That I attended deceased from January 26, 1923, to January 29 1923, that I last saw h[illegible] alive on Jan 29, 1923, and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:

Acute Mastoiditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Broncho Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 1/26/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Chas Leslie Stewart M. D.

1/24, 1923 (Address) 1738 6. 28th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fordsville Augusta Co Va

DATE OF BURIAL: Jan 31st 1923

20 UNDERTAKER: Bertram Lyon

ADDRESS: 1723 N. Fayette St

30 1923

NAME (PRINTED), WITH PENCIL OR INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71799 HEALTH DEPARTMENT—CITY OF BALTIMORE D71799

CERTIFICATE OF DEATH.

Registered No. C 90

1-PLACE OF DEATH

City of BALTIMORE: (No. Somerset Apartments St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward A. Griffith

(Residence in Baltimore: No. Somerset Apartments St.; 68 yrs., 3 mos., 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, October (Month) 27 (Day) 1854 (Year)

7-AGE. 68 yrs. 3 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Tailors' Trimmings

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John A. Griffith.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Mary A. Dowling.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond Griffith, (son)

(Address) Salisbury, Md.

15- JAN 30 1923 Robert P. Harrison, 192 Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 27 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, au (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John H. Harrison M. D.
(Coroner.)
Jan 29 1923 (Address) 2202 Boston

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
New Cathedral Cemetery	Jan-31-23 19

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71800 D71800

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #425 Hawthorne Road ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Yearley Jr.

(a) RESIDENCE NO. 425 Hawthorne Road ST., 27 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? 79 yrs. 7 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene Judik Yearley

6 DATE OF BIRTH (month, day, and year) June-19-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	79	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer Alex. Yearley & Son.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thos. C. Yearley

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza. A. Simpson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss Frances J. Yearley (daughter)
(Address) 425 Hawthorne Road, City

JAN 30 1923 Robert P. Harris, 19
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 20th, 1923, to Jany 29, 1923,

that I last saw h is alive on Jany 29, 1923,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Organic dis. of Heart Arteri-sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symp. & Post Mort

(Signed) Chas. O'Donovan, M. D.

Jan 30, 1923 (Address) 5 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Jan-31-23

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

D71801 | HEALTH DEPARTMENT—CITY OF BALTIMORE | D71801

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Saratoga & Holliday sts St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry L. Duvall

(Residence in Baltimore: No. 2206 N. Charles St. (12 Ward) St.; 69 yrs. 5 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: May (Month) 30 (Day) 1853 (Year)

7-AGE: 69 yrs. 5 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cashier
(b) General nature of industry, business, or establishment in which employed (or employer): Md Meter Co.

9-BIRTHPLACE, (State or Country): Balt city Md

PARENTS.

10-NAME OF FATHER: Mr Bidnall

11-BIRTHPLACE OF FATHER, (State or Country): Balt Md

12-MAIDEN NAME OF MOTHER: Emilia Trudall

13-BIRTHPLACE OF MOTHER, (State or Country): Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A K Dodson

(Address) 2206 N Charles St

15- JUN 3 01923 Robert P. Barrick, 192.....

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 29 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or Inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or Inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) One hour

CONTRIBUTORY (Secondary) Don't Know (Duration) ....yrs. ....mos. ....ds.

(Signed) A K Goodwin M. D. (Coroner.)

Jan 30 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery — DATE OF BURIAL, Jan 31 1923

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

1—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co. 1000 Blks.

D71802 HEALTH DEPARTMENT—CITY OF BALTIMORE D71802

CERTIFICATE OF DEATH. 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Federal St St.: 9 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis E. Herrman

(a) RESIDENCE. No. 1212 Federal St St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): April 18 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: No

(b) General nature of industry, business, or establishment in which employed (or employer): No

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Frank H. Herrman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Anna Elizabeth Seibel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Frank E. Herrman 1213 E Federal St

15 Filed ..... 19..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1923, to Jan 30, 1923, that I last saw him alive on Jan 29 1923, and that death occurred, on the date stated above, at 4.45 A. m.

The CAUSE OF DEATH* was as follows:

Diphtheria (toxic)

4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Nose Throat Clinic

(Signed) Richard Gorh M. D.

19 (Address) 731 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Jan. 31 1923
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	724 E. Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

301923

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonin," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pharyngeal & Tonsillar

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71803

CERTIFICATE OF DEATH.

31 D71803

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Eutaw ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Hunter

(Residence in Baltimore: No. 3 Eutaw ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 29, 1884 (Month) (Day) (Year)

7-AGE, 38 yrs. — mos. 30 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Andrew Ebenowetth

11-BIRTHPLACE OF FATHER (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER Mary E Haas

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm. Hunter

(Address) 3 Eutaw ave

15-

Filed ....., 191....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

JAN 30 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 28, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 21 1921, to Jan 28 1923, that I saw h er alive on Jan 27 1923, and that death occurred, on the date stated above, at 11.15 m.

The CAUSE OF DEATH* was as follows:

.....

Pulmonary Tuberculo

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. H. Hunter M. D.

1-29, 1923 (Address) 2500 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel

DATE OF BURIAL, Jan 31, 1923

20-UNDERTAKER Henry Lietz

ADDRESS 1203 N. Broadway

13.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71804

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D71804

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 331 N. Fulton Ave ST., 19 WARD)

2-FULL NAME Elizabeth H. R. Grass

(a) RESIDENCE NO. 331 N. Fulton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. P. Grass

6 DATE OF BIRTH (month, day, and year): Jan 27 - 1836

7 AGE: Years 87 Months ✓ Days 1 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: a

(b) General nature of industry, business, or establishment in which employed (or employer): a

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Noah Faubrandt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Miss Lillie Grass

(Address): 331 N. Fulton Ave

15 JAN 30 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28" 1923.

17 I HEREBY CERTIFY, That I attended deceased from Oct 10" , 1922 , to June 28" , 1923 ,

that I last saw her alive on June 28" , 1923 ,

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Cerebro Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence of case

(Signed) Herbert E. Zepp, M. D.

, 19 (Address) 3048 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan 31 1923

20 UNDERTAKER: W. J. Tichnor & Son — ADDRESS: Walbrook

JAN 30 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

D71805

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4908 Crowson Ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Bennett

(a) RESIDENCE No. 4908 Crowson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robt M Bennett

6 DATE OF BIRTH (month, day, and year): Oct 28-1853

7 AGE — Years: 69 — Months: 3 — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Nicholas Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Annie Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs Florence L Smith 4908 Crowson Ave

15 Registrar: Robert F. Harrison, Burial Permit Clerk.

JAN 30 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 14 1922 to Jan 29 1923.

that I last saw her alive on Jan 29 1923.

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) two yrs. mos. ds.

CONTRIBUTORY (Secondary): Gradual decline

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray & Microscopic Examination

(Signed) Thos. H. Phillips, M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 31 1923

20 UNDERTAKER: Wm J Tickner & Sons — ADDRESS: N. Y. Ave.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71806

CERTIFICATE OF DEATH.

129

D71806

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2414 Eutaw Place ST., 13 WARD)

2-FULL NAME Mary Green King

(a) RESIDENCE NO. 2414 Eutaw Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry T. King

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Jerome Lewis King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Mary Virginia Hazelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Mrs Sanders Thalheimer (Address) 2414 Eutaw Place

15 Filed JAN 31 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1923, to Jan 30, 1923, that I last saw her alive on Jan 30, 1923, and that death occurred, on the date stated above, at 7. a m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis - arterio-sclerosis + (influenza)

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) bronchs - pneumonia + anemia (duration) ... yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Leitz, M. D.

1-30, 1923 (Address) 2040 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL 2/ 1923

20 UNDERTAKER J. Ahrens & Co ADDRESS 1611 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71807

CERTIFICATE OF DEATH.

X 100-00

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3415 Duvall Ave ST., (Ernest & Pk) (13) WARD)

2-FULL NAME Maria Skinner Bird.

(a) RESIDENCE NO. 3415 Duvall Ave ST., Forest Park. WARD (Penn Garth Md)

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1848.

7 AGE: Years 75 yrs. Months Days If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Frederick Calvert Co. Md.

PARENTS

10 NAME OF FATHER Lewis Skinner.

11 BIRTHPLACE OF FATHER (city or town) Calvert (State or country) Prince Frederick Co. Md.

12 MAIDEN NAME OF MOTHER Sarah Lancaster.

13 BIRTHPLACE OF MOTHER (city or town) Charles Co. (State or country) Md.

14 Informant Mrs. E. H. Diggs

(Address) 3415 Duvall Ave.

15 Filed JAN 31 1923 ROBERT N. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1922 to Jan. 31, 1923.

that I last saw h... alive on 1-31 — , 1923

and that death occurred, on the date stated above, at 3a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia.

(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary) Senility.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alfred M. Lyell M. D.

, 19 (Address) 3705 Lib. Nth Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Jane cemetery CALVERT CO PRINCE FREDRICK MD

DATE OF BURIAL 2/1 1923

20 UNDERTAKER ROBERT BROOKS & SON

ADDRESS CALHOUN HOLLINS ST

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71808 HEALTH DEPARTMENT—CITY OF BALTIMORE D71808

CERTIFICATE OF DEATH.

REGISTERED No. C 74

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 618 So. Bethel St.: 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Gluck

(Residence in Baltimore: No. 618 So. Bethel St St.: 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Widow

6-DATE OF BIRTH: Unknown, 1 (Month) (Day) (Year)

7-AGE: about 64 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Louis Dannenfelser

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Mary Leppert

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Dannenfelser

(Address) 618 So. Bethel St

15- Filed JAN 31 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 28th, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

1 day or over (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) — (Duration) yrs. mos. ds.

(Signed) Geo. A. Horton M. D. (Coroner)

Jan 30th 1923 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Balto. Md

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Co. DATE OF BURIAL, Jan. 31. 1923

20-UNDERTAKER Louis Heeman ADDRESS 325 Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D71809

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71809

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2016 E. Chase St. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paolo Pipitone

(Residence in Baltimore: No. 2016 E Chase St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

6-DATE OF BIRTH: Sept. 10th, 1922 (Month) (Day) (Year)

7-AGE: ... yrs. 4 mos. 20 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto md.

PARENTS:

10-NAME OF FATHER: Paolo Pipitone

11-BIRTHPLACE OF FATHER, (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Grace Poggis

13-BIRTHPLACE OF MOTHER, (State or Country): Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paolo Pipitone

(Address) 2016 E Chase St

15- JAN 3 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 30 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... yrs. ... mos. 3rd ds.

CONTRIBUTORY (Secondary) ... (Duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Hall (Coroner.) M. D.

1-30 1923 (Address) 938 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer DATE OF BURIAL, 1/31/23 19...

20-UNDERTAKER: George J. Fuller ADDRESS 1735 Harford Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71810

HEALTH DEPARTMENT—CITY OF BALTIMORE

37 D71810

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 Darley Ave. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene M. Lusinski

(a) RESIDENCE No. 1635 Darley Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Frank P. Lusinski

6 DATE OF BIRTH (month, day, and year) July 4, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City (State or country) Md.

PARENTS

10 NAME OF FATHER Robert R. Hanson

11 BIRTHPLACE OF FATHER (city or town) Balto City (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Schley.

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Frank P. Lusinski (Address) 1635 Darley Ave.

15 Filed JAN 31 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1923, to June 30, 1923, that I last saw h. alive on June 29, 1923, and that death occurred, on the date stated above, at 6 05 Am.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W Donderew, M. D.

, 19 (Address) 1714 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 2/2 1923

20 UNDERTAKER Geo L. Ruth

ADDRESS 1755 Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71811

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71811

CERTIFICATE OF DEATH.

99-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2031 Boyd St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Anna C Peddicord

(Residence in Baltimore: No. 2031 Boyd St.; yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Aug (Month) 26 (Day) 1882 (Year)

7-AGE. 40 yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of Industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Charles Mercer

11-BIRTHPLACE OF FATHER, (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Martha Carns

13-BIRTHPLACE OF MOTHER, (State or Country). Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Mercer

(Address) 2631 Fredericks ave

15. Filed JAN 31 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 30 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) yrs. mos. 10 ds.

(Signed) James M Fenlon M. D. (Coroner.)

Jan 30 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park — DATE OF BURIAL. Feb 2 1923

20-UNDERTAKER. George C. Schwab — ADDRESS 2101 Eutaw Ave.

Directions: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D71812 HEALTH DEPARTMENT—CITY OF BALTIMORE D71812

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Tiggle

(a) RESIDENCE NO. 577 W. Preston st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mona Tiggle

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. Tiggle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Louisa Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) Municipal Tb. Hospital

15 Filed JAN 31 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1922, to Jan. 29, 1923.

that I last saw him alive on Jan. 29, 1923,

and that death occurred, on the date stated above, at 5.20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dadaplicos M. D.

1-29-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edmund Hensley

DATE OF BURIAL 1923

UNDERTAKER Ed Andrews Cond

ADDRESS 1[illegible]

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should take CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71813

CERTIFICATE OF DEATH.

D71813

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Infant Herman

(Residence in Baltimore: No. 1302 E. Monument St.; yrs., mos., ds.)

Duplicate of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, ... 1..... (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 2 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto md

PARENTS.

10-NAME OF FATHER, Harry Herman

11-BIRTHPLACE OF FATHER, (State or Country), Balto md

12-MAIDEN NAME OF MOTHER, Jennie Dawley

13-BIRTHPLACE OF MOTHER, (State or Country), Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hosp.

(Address).....

15- Filed JAN 3 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 29 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an injury (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said injury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured uvula

(7 months previous)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Falls M. D. (Coroner.)

1-28 1923 (Address) 504 E. Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

JOHNS HOPKINS HOSPITAL JAN 31 1923

20-UNDERTAKER Commissioner of Health, ADDRESS

Per Wm. E. WOODALL

Spec.—1-10-21—M&T—1500 Bks.

Boyce

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71814

D71814

CERTIFICATE OF DEATH.

117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 70 WARD)

2-FULL NAME Harry Boyce

(a) RESIDENCE NO. 3006 Eagle St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. 1 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs M Boyce

(Address) 2017 W Lafayette Ave

15 Filed JAN 3 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30- 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 26 1923 to Jan 30 1923

that I last saw him alive on Jan 30 1923

and that death occurred, on the date stated above, at 6 10 8 m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis - perforated -
Early Peritonitis -
Infocardites -

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho - pneumonia.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? yes Date of Jan. 26-23

Was there an autopsy? No -

What test confirmed diagnosis? Clinical - Autopsy

(Signed) W C Caldwell M. D.

1/30, 1923 (Address) #8873 -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lehren Mash Road — DATE OF BURIAL 1/31 1923

20 UNDERTAKER Jack Levis — ADDRESS 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71815 D71815

CERTIFICATE OF DEATH.

X 11-001

1-PLACE OF DEATH Miss. S.A. Wiederhold

CITY OF BALTIMORE: (No. Roland Ave Lake Av ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustin D. Solla

(a) RESIDENCE NO St Augustine Florida WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
about	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tobacco Planter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER Felix Solla

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Record (Address)

15 JAN 31 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1922, to Jan. 31, 1923, that I last saw h.... alive on Jan. 30, 1923, and that death occurred, on the date stated above, at 4 55 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore N. Morrison, M. D.

, 19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Augustine Flosdia — DATE OF BURIAL Jan 31 1923

UNDERTAKER A.J. Jenkins & Son Co — ADDRESS Orchard & McCulloh

Mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71816

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71816

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2757 Raynor Ave. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John James Purcell

(a) RESIDENCE NO. 2757 Raynor Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, ~~or Divorced~~, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Laura L Purcell

6 DATE OF BIRTH (month, day, and year) 3-25-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Building Inspector 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Purcell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Rebecca Easter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Laura L. Purcell

(Address) 2757 Raynor Ave.

15 Filed JAN 3 1923 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1922, to Jan 29, 1923.

that I last saw h~~e~~ alive on Jan 29, 1923

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) ✓ yrs. ✓ mos ✓ ds.

CONTRIBUTORY (Secondary) Malignant Cachexia

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? X Ray Oliye Exam.

(Signed) John A. Prather M. D.

Jan 31, 1923 (Address) 1219 Eutaw Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Feb 1 1923

20 UNDERTAKER Henry W Junkin & Sons

ADDRESS McCulloh-Eichard Sts

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71817

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71817

CERTIFICATE OF DEATH.

3 V

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospt. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Hutton

(a) RESIDENCE NO. Montrose Apts ST., (Not Royal Ave near Charles St) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, ~~widowed~~, or divorced HUSBAND of (or) WIFE of: Agnes

6 DATE OF BIRTH (month, day, and year): June 7 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not known

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Maryland

PARENTS

10 NAME OF FATHER: H Henry Hutton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D C

12 MAIDEN NAME OF MOTHER: Meta Van Mars

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Dr C. H Wyatt

(Address): Balto Md

15 Filed JAN 31 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/30/23

17 I HEREBY CERTIFY, That I attended deceased from 1/18/23 19 , to 1/30/23 19 ,

that I last saw h~~im~~live on 1/30/23 19 ,

and that death occurred, on the date stated above, at 11½ m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lab findings

(Signed) No Attendance, M. D.

19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bellemont Cem

DATE OF BURIAL: Feb 1 1923

20 UNDERTAKER: H J Eakins & Son Co

ADDRESS: Orchard & Fulton Aves

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D71818

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 18 WARD)

2-FULL NAME Mrs. Mary J. Doyle

(a) RESIDENCE NO. 5 S. Schroeder ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Doyle

6 DATE OF BIRTH (month, day, and year) March 24 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew O'Keefe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Johanna Toole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John T. Doyle

(Address) 5 S. Schroeder St.

15 Filed JAN 31 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1923, to Jan. 29, 1923, that I last saw h 25 alive on Jan 29, 1923, and that death occurred, on the date stated above, at 9.05 P m.

The CAUSE OF DEATH* was as follows: Carcinoma Liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cachexia (duration) yrs. mos. 6 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) J. J. Swagno, M. D.

1/30 1923 (Address) City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cem DATE OF BURIAL Feb 1st 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71819

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 ~ D71819

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 933 E Chase ST., 10 WARD)

2-FULL NAME Edward F. Horgan Jr.

(a) RESIDENCE NO. 933 E Chase ST., 10 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 8 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Edward F. Horgan

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mabel G. Lang

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mr. Edward F. Horgan
(Address) 933 E Chase St

15 Filed JAN 31 1923 19 ROBERT R. KRAUTLER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 26 1923, to Jan 30 1923.

that I last saw h alive on Jan 30 1923.

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Spasm & Laryngo-
of the Coughing (duration) Tube out Sudden ds.

18 Where was disease contracted if not at place of death? 933 E Chase

Did an operation precede death? Intubated Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

1/31 1923 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan 31 1923
20 UNDERTAKER	ADDRESS
Henry Hoch Son	1301 E Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71820 HEALTH DEPARTMENT—CITY OF BALTIMORE D71820

90

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3520 Reisterstown Rd. ST., 15 WARD)

2-FULL NAME Mary Ellen Thornton

(a) RESIDENCE No. 3520 Reisterstown Rd. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H.Thornton

6 DATE OF BIRTH (month, day, and year) Nov. 15 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	64	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) House-wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John T.Hope

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Martha A.Clements

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Miss Edith Hope (Sister)
(Address) 1003 W.Lanvale St.

15 FILED JAN 31 1923 ROBERT R. KRAUTH, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1923, to Jan 30, 1923,
that I last saw her alive on Jan 30, 1923
and that death occurred, on the date stated above, at 3.30 A.M.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ... yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocardial degeneration, arteriosclerosis

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Mullin P. Hill M. D.

, 19 (Address) Ingleside & Reisterstown Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Feb 1 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Lights

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71821

REGISTERED No. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 E. Lanvale ST.: 12 WARD)

2-FULL NAME Frank K. Habercam

(a) RESIDENCE. No. 423 E. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Madge Habercam

6 DATE OF BIRTH (month, day, and year) Sept 29 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Mfg

(b) General nature of industry, business, or establishment in which employed (or employer) 817

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Habercam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mad Hambelfeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Habercam
(Address) 423 E Lanvale St

JAN 31 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1922, to Jany 28, 1923, that I last saw h.i.m alive on Jany 28, 1923, and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

, 19 (Address) 425 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan 31 1923

20 UNDERTAKER E. A. Windsor Jr ADDRESS 501 E 22 St

INSTRUCTIONS

This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71822

CERTIFICATE OF DEATH.

114 D71822

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1237 Division ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence E. Sinclair

(a) RESIDENCE. No. 1237 Division ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Sept 20-1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hair Dresser Manicurist

(b) General nature of industry, business, or establishment in which employed (or employer) Hair dresser

(c) Name of employer Her Own Employer.

9 BIRTHPLACE (city or town) & Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER C. W. Wright

11 BIRTHPLACE OF FATHER (city or town) Centerville (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary C. Slater

13 BIRTHPLACE OF MOTHER (city or town) Cambridge (State or country) Maryland.

14 Informant E. Ellsworth S. Wright (Address) 20 Mosher St

15 Filed JAN 31 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from JAN. 26th 1923, to JAN. 30th, 1923, that I last saw h.. alive on JAN. 30th, 192.., and that death occurred, on the date stated above, at 8-15-A m.

The CAUSE OF DEATH* was as follows:

Parenchymatous nephritis (acute)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Gastro-Enteritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? no Date of

Was there an autopsy? No. Only

What test confirmed diagnosis? Clinical findings

(Signed) J. Bunnell Forgo, M. D.

19 (Address) 746 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ivy Auburn Cmty	2-2 1923

20 UNDERTAKER George H. Holland ADDRESS 1631 Druid Hill Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71823

CERTIFICATE OF DEATH.

D71823

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 403 S. Payson ST., 20 WARD)

2-FULL NAME Annie Rheb

(a) RESIDENCE NO. 403 S. Payson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 19, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Louis Rheb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Fischer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Trinchard Heiser

(Address) 403 S. Payson

15 JAN 3 1 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 10, 1901, to Jan 29, 1923,

that I last saw her alive on Jan 28, 1923,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Fragilitas Ossium +

Pagets disease

(duration) 60 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Coma

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H E Knight, M. D.

1/29, 1920 (Address) 1002 N. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Jan 31 1923

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1531 Lombard

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71824

CERTIFICATE OF DEATH.

101-001 D71824

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 Dover St. ST., W WARD)

2-FULL NAME Frank Williams

(a) RESIDENCE NO. 317 Dover St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 6, 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) — 040

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Virginia Grant

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Annie Ross
(Address) 317 Dover St

15 Filed JAN 31 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29 1923.

17

I HEREBY CERTIFY, That I attended deceased from Dec 25, 1922, to Jany 29, 1923,

that I last saw him alive on Jany 27, 1923,

and that death occurred, on the date stated above, at 10 (—) 9, m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos 4 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) H. L. Smith, M. D.

, 19 (Address) 109 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Jan 31 19 23
20 UNDERTAKER Wm H. Burke	ADDRESS 406 W. Lanvale St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001

D71825

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 W. Fayette ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) York Pa

2-FULL NAME Eugene E. Nicholas

(a) RESIDENCE No. 717 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 11 mos. — ds. How long in U. S., If of foreign birth? Life time mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 18 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) York Penna

PARENTS

10 NAME OF FATHER Curtis V. Nicholas

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Penna

12 MAIDEN NAME OF MOTHER Edith Nunemaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Barnes Pa

14 Informant Edith Nicholas

(Address) 717 W. Fayette St

15 FILED JAN 31 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1923, to Jan 31st, 1923, that I last saw him alive on Jan 30, 1923, and that death occurred, on the date stated above, at 5.30 a m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 717 W Fayette

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Howard C. Dilow, M. D.

, 19 (Address) 3706 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL York Pa — DATE OF BURIAL 1/31/23

20 UNDERTAKER W J Sulzner & Son — ADDRESS York Pa

ATTENTION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71826

CERTIFICATE OF DEATH.

114 D71826

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2918 O. Donnell ST., 1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Foertschbeck

(a) RESIDENCE NO. 2918 O. Donnell. ST., 1 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 52 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late John Foertschbeck

6 DATE OF BIRTH (month, day, and year): July 16th 1852

7 AGE — Years: 70 — Months: 6 — Days: 13 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED: Retired
(a) Trade, profession or particular kind of work: Store Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer: self

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Johann Foerschbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Kunigunda Foertschbeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Barbara Loeffler
(Address): 2918 O Donnell St

15 JAN 31 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Jan 29, 1923, that I last saw her alive on Jan 28, 1923, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(also cardiac hypertrophy)

(duration) ... yrs. ... mos 14 ds.

CONTRIBUTORY (Secondary): exhaustion

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. A. Krueger, M. D.

1/31 1923 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery — DATE OF BURIAL: Feb 2nd 1923

20 UNDERTAKER: Lilly & Zeile — ADDRESS: 4038 Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Ahles. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71827

CERTIFICATE OF DEATH.

74001

D71827

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Bank ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ahles.

(a) RESIDENCE NO. 2016 Bank ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 5 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Mary Ahles.

6 DATE OF BIRTH (month, day, and year) Aug 20th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 845

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Fred Ahles.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Florence Schindler (daughter)

(Address) 1522 E. Eager St.

15 JAN 31 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28th 1923

17 I THEREBY CERTIFY, That I attended deceased from Jan 17, 1923, to Jan 29, 1923, that I last saw him alive on Jan 26, 1923 and that death occurred, on the date stated above, at 5-45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (")

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Typical signs

(Signed) Geo. Keller, M. D.

1/30, 1923 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Lutheran Cemetery

DATE OF BURIAL: Feb 1st 1923

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 1038 N. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71828

CERTIFICATE OF DEATH.

159-002

D71828

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 N Carey ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Godfrey.

(a) RESIDENCE NO. 706 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Wm L. Godfrey

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Evelyn V Flaherty

13 BIRTHPLACE OF MOTHER (city or town) Canton

(State or country) Ohio

14 Informant Wm L. Godfrey

(Address) 706 N Carey St

15 Filed JAN 31 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 30, 1923, to Jan 31, 1923,

that I last saw h in alive on Jan 30, 1923,

and that death occurred, on the date stated above, at 12-30 A m.

The CAUSE OF DEATH* was as follows:

Premature about 6 Mo.

Membranes Ruptured

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. L. Fair, M. D.

, 19 (Address) 12 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

London Park Cemetery Feb 1 19 23

20 UNDERTAKER Putnam Moore ADDRESS 1125 Eutaw St

INSTRUCTIONS: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71829 HEALTH DEPARTMENT—CITY OF BALTIMORE D71829

CERTIFICATE OF DEATH.

Registered No. C. 179

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Savoy

(Residence in Baltimore: No. 634 Pitcher St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	colored	single

6-DATE OF BIRTH, June (Month) 16 (Day) 1906 (Year)

7-AGE, 16 yrs. 6 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): Potato chip Factory

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Ernest Savoy

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Ellen Clark

13-BIRTHPLACE OF MOTHER, (State or Country), Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earnest Savoy

(Address) 634 Pitcher St

15- Robert F. Garrison, Filed 1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 29 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or Inquiry.) find that said deceased came to Their death on the day stated above.

The CAUSE OF DEATH* was as follows:

3° Burns over most of body accident by throwing coal oil on fire

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Fenton M. D. (Coroner.)

Jan 30 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents)
At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? 623 Pitcher St

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, Laurel DATE OF BURIAL, Feb 1 1923

20-UNDERTAKER, Warren Coding ADDRESS Hyncamp

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

31 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71830

CERTIFICATE OF DEATH.

D71830

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3029 Cedar Ave ST.; 13 WARD)

2-FULL NAME Elizabeth Deitz

(a) RESIDENCE. No. 3029 Cedar Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of John C Deitz

6 DATE OF BIRTH (month, day, and year) Feb 13 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Amos Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Matilda Landes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Harry Deitz
(Address) 3029 Cedar Ave

15 JAN 31 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 15 1922 to Jan 30 1923, that I last saw her alive on Jan 29 1923 and that death occurred, on the date stated above, at 11.40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Illness supposed (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan 24/23

Was there an autopsy? Unnecessary.

What test confirmed diagnosis? Exploratory Abdomen

(Signed) R B Norment M. D.

1-30 1923 (Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL Feb 2 1923

20 UNDERTAKER D S Marshall ADDRESS 3539 Fall Rd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71831

D71831

CERTIFICATE OF DEATH

1-PLACE OF DEATH Boy Mem'l Hospital

REGISTERED NO. 14-00

CITY OF BALTIMORE: (No. ..... ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Brandt.

(a) RESIDENCE NO. 29 E. Lettings ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Five yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Brandt

6 DATE OF BIRTH (month, day, and year) 4-24-18 52

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Do

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Do

14 Informant Boy Mem'l Hospital (Address) Balto Md.

15 Filed ..... , 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk

3 11923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1921, to Jan 30 1923

that I last saw her alive on Jan 29, 1923

and that death occurred, on the date stated above, at 1:40 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

..... (duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home of Deceased

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. Goldsmith, M. D.

, 19 (Address) Boy Mem'l Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 2/1 1923

20 UNDERTAKER I. Frew McCully

ADDRESS 130 E. Fort

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-23—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71832

CERTIFICATE OF DEATH.

91-00 D71832

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 906 E. Biddle ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Gallagher

(a) RESIDENCE NO. 906 E. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma J. Gallagher

6 DATE OF BIRTH (month, day, and year): March 11 1847

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
75	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Plumber

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Emma J. Gallagher

(Address) 906 E. Biddle St

15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 30" 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/12, 1922, to 1/30, 1923.

that I last saw h alive on 1/30, 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Senility

Arteriosclerosis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Bernard Gorsuch, M. D.

1/30, 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 2/2" 1923

20 UNDERTAKER: Chas. Flood & Son

ADDRESS: W. Mt. Royal Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71833

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D71833

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 Patterson Park Ave ST., 8 WARD)

2-FULL NAME Anna Elizabeth Smith

(a) RESIDENCE NO. 1106 Patterson Park Ave ST., 8 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Baby

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Child

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edward R Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Behlke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edward Smith
(Address) 1106 Patterson Park Ave

15 Filed AUG 1 ....., 19 Registrar

3 1 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 30 1923

17 I HEREBY CERTIFY, That I attended deceased from January 28, 1923, to January 30, 1923, that I last saw her alive on January 29, 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia & Convulsions

(duration) Pneumonia 3 days Convulsions 3 hrs yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. F. Carman, M. D.

1-31-1923 (Address) 1701 E Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St James Cemetery Govans Md | DATE OF BURIAL: Feb 1 1923

20 UNDERTAKER: Wm J Miller | ADDRESS: 2334 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71834

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D71834

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 r 3 Williams St., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emelie Miller

(a) RESIDENCE NO. 14 r 3 Williams St., 24 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a [redacted], widowed, [redacted] of (or) WIFE of Geo N. Miller

6 DATE OF BIRTH (month, day, and year): 7/M/62

7 AGE: Years 60 | Months 6 | Days 4 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Fred Graf.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Mary Wolf.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: G. Fred Miller

(Address): 14 r 3 Williams St

15 Filed Jan 31 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1923, to Jan 28, 1923, that I last saw h[redacted]ive on Jan 28, 1923, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

about (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles Eichenbrod M. D.

Jan 31, 1923 (Address) 1412 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: 2/1 1923

20 UNDERTAKER: J. J. Fahey & Son

ADDRESS: 1318 Light St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

31 1923

Mina

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D71835

D71835

CERTIFICATE OF DEATH.

101-80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 Druid Hill Ave ST.: 17 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Mina

(a) RESIDENCE. NO. 414 Druid Hill Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Mina

6 DATE OF BIRTH (month, day, and year) Jan. 30-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Office Bldg. 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) D.C.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Emma Mina (Wife) (Address) 414 Druid Hill Ave

15 Filed 3 1 1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 28 1923, to Jan 30 1923, that I last saw him alive on Jan 30 1923, and that death occurred, on the date stated above, at 12.10 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) J. H. Hanna M. D.

Jan 19 23 (Address) 1128 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Feb. 1" 1923

20 UNDERTAKER Jno. M. Johnson

ADDRESS 1234 Ethan St.

Spec.—1-10-21—M&T—1500 Blks.

D71836

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D71836

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Blyer

(a) RESIDENCE NO. 510 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year) Jan 30, 1923

7 AGE: Years ✓ Months ✓ Days ✓ If LESS than 1 day, hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER Louis Blyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Sylvia Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Louis Blyer (Address) 510 Mulberry St.

15 Robert P. Harrison, Registrar

N 3 1923, 19

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1923, to Jan 30, 1923

that I last saw him alive on Jan 30 1923

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Dystocia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Prematurity (8 mo)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) George E. Shannon, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: Feb 1 1923

20 UNDERTAKER: W. M. Routson — ADDRESS: 230 N Grand

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D71837

D71837

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma E. Lowe

(a) RESIDENCE NO. Westminster Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Known

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE: Years 60; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Westminster Md.

PARENTS

10 NAME OF FATHER: Jacob Shaver

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Christina Leister

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Hospital Records

15 Filed 1923 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 31 1923

17 I HEREBY CERTIFY, that I attended deceased from Jany — 1923, to Jany 31 1923

that I last saw her alive on Jany 31 1923

and that death occurred, on the date stated above, at 248 a. m.

The CAUSE OF DEATH* was as follows:

Mesenteric Thrombosis

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy

(Signed) D F S Jones, M. D.

1/31 1923 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster

DATE OF BURIAL: Feb 3 1923

20 UNDERTAKER: H M Routson

ADDRESS: 230 N Greene

Spec.—8-24-14—M. & T.—2000 Bks.

D71838

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71838

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 245 W. Preston ST. 11 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Fort

(Residence in Baltimore: No. 245 W. Preston st St. 30 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem.

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Dec. 13, 1866
(Month) (Day) (Year)

7-AGE, 56 yrs. 1 mos. 16 da.

If LESS than 1 day, ... hrs. or ..... mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Balto. Md,

PARENTS.

10-NAME OF FATHER. Michael Spearman

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country). England,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Horace J. C. Fort

(Address) 245 W. Preston St

15-

Robert P. Harrison,

Burial Permit Clerk. Registrar.

JAN 31 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Jan. 30th, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 29 1923, to Jan 30th 1923, that I saw her alive on Jan 30th 1923, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral)

(Duration) ..... yrs. ..... mos. 24 hrs da.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 2 hrs da.

(Signed) Thos. H. Bullock M. D.

Jan. 31, 1923 (Address) 1100 W. Lafayette Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. Feb. 1..., 1923

20-UNDERTAKER W M Rowson

ADDRESS 2305 N Gilmore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71839 D71839

CERTIFICATE OF DEATH.

38

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 22 WARD)

2-FULL NAME Robert Carpenter

(a) RESIDENCE NO. 725 Grindells Court. ST., 22 WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	54	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER Robt. Carpenter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Municipal Hospital Records.

15 JAN 31 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from January 17, 1923, to January 30, 1923, that I last saw him alive on January 29, 1923, and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 29 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tabes Dorsalis (Syphilitic) (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Cl. Was. C.S.F.

(Signed) Clyde McNeil, M. D.

1/30/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid cemetery

DATE OF BURIAL: Feb 1 1923

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 Orleans St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71840

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D71840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH ~~JOHNS HOPKINS HOSPITAL~~ 5

CITY OF BALTIMORE: (No. 507 Somerset ST., 5 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Manning

(a) RESIDENCE No. 507 Somerset ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Ed Manning

6 DATE OF BIRTH (month, day, and year) May 29 1893

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	8	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Elroy
(State or country) North Carolina

PARENTS
10 NAME OF FATHER Charles MacLean
11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)
12 MAIDEN NAME OF MOTHER Nancy (unknown)
13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Records
(Address)

15 Filed ....., 19 .....
Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 30 1923

17
I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1923, to Jan. 30, 1923,
that I last saw her alive on Jan 30, 1923,
and that death occurred, on the date stated above, at 11 25 a. m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) W. W. Gray, M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elroy N. C.
DATE OF BURIAL Feb 1923

20 UNDERTAKER Jno J. G. Locks
ADDRESS 1302 Hoffman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1923

Spec.—8-24-14—M. & T.—3000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71841 — 154-002 — D71841

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5108 Milford Ave St.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Keyser

(Residence in Baltimore: No. 5108 Milford Ave St.; 1 yrs., ... mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Infant

6-DATE OF BIRTH, January (Month) 13 (Day), 1923 (Year)

7-AGE, ... yrs. ..... mos. 18 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles Edwd Keyser

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Eastwood Barker

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas E. Keyser

(Address) 5108 Milford Ave

15-

Filed ..... Robert P. Harrison. Registrar.

3 1 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 31st (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 13 1923, to Jany 31 1923, that I saw him alive on Jany 30 1923, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Non-closure of Foramen Ovale
(Blue Baby.)
(Duration) ..... yrs. ..... mos. 18 ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Reaver M. D.

Jany 31, 1923 (Address) 1938 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery

DATE OF BURIAL, Feb 1..., 1923

20-UNDERTAKER Henry Lutz

ADDRESS 1203 N Broadway

Henry Lutz

Notice of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D71842 HEALTH DEPARTMENT—CITY OF BALTIMORE D71842

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bronings and St. Joseph's Hospital St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Richard S. Jenkins

(Residence in Baltimore: No. 218 N. Ann St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed or Divorced, (Write the word.): Single

6-DATE OF BIRTH: March (Month) 18 (Day) 1896 (Year)

7-AGE: 26 yrs. 10 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer): Brick Yard

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: John W. Jenkins

11-BIRTHPLACE OF FATHER, (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Cora Balkey

13-BIRTHPLACE OF MOTHER, (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Jenkins Wife

(Address) 26 N. Eden St

15- 1923 Robert P. Harrison, 192 Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 28 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy-Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage - caused by pistol shot wound of left lung & heart

Pistol fired by Sadie Rollins

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) J. S. H. Fuller M. D. (Coroner.)

1-31 1923 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Laurel Cemetery Feb 1 1923

20-UNDERTAKER. ADDRESS

Milton Davis 315 N Eden St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Elvira Rivera

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71843

CERTIFICATE OF DEATH.

4 X 90

D71843

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 W. Mulberry ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvera Rivira

(a) RESIDENCE. NO. 116 W Mulberry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. V mos. ds. How long in U. S., if of foreign birth? yrs. V mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Rivera

6 DATE OF BIRTH (month, day, and year) 12-10-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Porto Rico

PARENTS

10 NAME OF FATHER Faustino Rosa

11 BIRTHPLACE OF FATHER (city or town) Porto Rico (State or country)

12 MAIDEN NAME OF MOTHER Theresa Bonnelly

13 BIRTHPLACE OF MOTHER (city or town) Porto Rico (State or country)

14 Informant Emilio Pourpart

(Address) 116 W Mulberry

15 Filed JAN 31 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1923, to Jan 31, 1923, that I last saw h[illegible] alive on Jan 30, 1923, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) Don't know yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? N Date of

Was there an autopsy? N

What test confirmed diagnosis? —

(Signed) N. E. Gonzales, M. D.

Feb 1, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Feb. 1 1923

20 UNDERTAKER Margaret G. Flynn ADDRESS 1407 Eight St.

Spec.—1-10-21—M&T—1500 Bks.

D71844 HEALTH DEPARTMENT—CITY OF BALTIMORE D71844

129

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 324 N Eutaw St. 4 WARD)

2-FULL NAME George B Boutelle

(a) RESIDENCE NO. 324 N Eutaw ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced. (write the word): Married
5a If married, widowed or divorced (or) WIFE of: Lauretta E Boutelle
6 DATE OF BIRTH (month, day, and year): June 9
7 AGE: Years 77 Months Days
If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Dental
(b) General nature of industry, business, or establishment in which employed (or employer): Supplies
(c) Name of employer: Own Business

9 BIRTHPLACE (city or town) (State or country): New Port Rhode Island

PARENTS
10 NAME OF FATHER: David R Boutelle
11 BIRTHPLACE OF FATHER (city or town) (State or country): New Hampshire
12 MAIDEN NAME OF MOTHER: Lizzie Bancroft
13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Hampshire

14 Informant: Lauretta E Boutelle
(Address) 324 N Eutaw Street

Filed ..... 19 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1923, to Jan 31, 1923, that I last saw him alive on Jan 30 - 1923 - and that death occurred, on the date stated above, at 6 29 m.

The CAUSE OF DEATH* was as follows:
Myocarditis - chronic -
Nephritis - chronic -
(duration) Several yrs. — mos — ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No —
What test confirmed diagnosis? Clinical
(Signed) ..... M. D.
Jan 31 1923 (Address) 1327 Park Ave —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Manchester New Hampshire
DATE OF BURIAL: Feb 2 1923

20 UNDERTAKER: William Buck
ADDRESS: 5026 North Ave

11923

Interred 1327 Park Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71845

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 1845

44 D. 71845

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2803 Fruitby - ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Howell

(a) RESIDENCE NO. 2803 Fruitby ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Taylor

6 DATE OF BIRTH (month, day, and year): April 5 1859

7 AGE — Years: 63 — Months: 9 — Days: 2 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Self. 034

(c) Name of employer: Self. Balto.

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Emma L Howell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Lydia Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs John Howell

(Address): 2803 Fruitby St

15 Filed Jan 30 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec-30- 1922, to Jan 29 1923

that I last saw h[illegible] alive on Jan 29 1923

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Pyloric)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): General debility

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? X Ray

(Signed) J. Stanley Gundry, M. D.

Jan 30 1923 (Address) 2900 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: 1923

20 UNDERTAKER: Wm Carter — ADDRESS: 052 E Balto

INSTRUCTIONS: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

3 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71846 | CERTIFICATE OF DEATH. | 25-001 | D71846

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 59 Darby St. ST., 13 WARD)

2-FULL NAME Dorothy M. Gordon.

(a) RESIDENCE NO. 59 Darby St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 3/1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	4	27.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country) Md.

PARENTS
10 NAME OF FATHER Hon F. Gordon.
11 BIRTHPLACE OF FATHER (city or town) Balto Co.
(State or country) Md.
12 MAIDEN NAME OF MOTHER Lillian E Eisenhart
13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Hon F. Gordon
(Address) 59 Darby St.

15 Filed ..... 19 ..... Robert F. Carlson
Burial Permit Clerk. Registrar

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 2nd, 1923, to Jan 31st, 1923,
that I last saw HER alive on Jan. 31st, 1923,
and that death occurred, on the date stated above, at 355 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) abt yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Chicken Pox
(duration) ..... yrs. abt mos. 10 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) Fridenham R. Clarke, M. D.
1/31 1923 (Address) Roland Park – 1st. John's Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hanover. | DATE OF BURIAL 2/1 1923.

20 UNDERTAKER WALTER DAVIS, FUNERAL DIRECTOR | ADDRESS 330 Pine St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71847

CERTIFICATE OF DEATH.

99-001

D71847

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 E. Barney ST., 23. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Loughlin.

(a) RESIDENCE NO. 204 E. Barney ST., 23. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 1[illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov, 13, 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2.	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Charles E. Loughlin.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Marie Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balti-ore, Md.

14 Informant John W. Loughlin.
(Address) 204. E. Barney St.

15 FEB 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1923, to Jan 31, 1923,
that I last saw him alive on Jan 30, 1923,
and that death occurred, on the date stated above, at 2-30 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Primary)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary) Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. R. Campbell M. D.

Jan 31, 1923 (Address) 1604 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Comtery. Feb, 1, 1923.	19
20 UNDERTAKER	ADDRESS
Mrs. J. E. Evans & Sons.	1428 S. Charles St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71848

CERTIFICATE OF DEATH.

31 D71848

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 S. Washington ST., 7 WARD)

2-FULL NAME Simon Scheder.

(a) RESIDENCE NO. 507 S. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Scheder.

6 DATE OF BIRTH (month, day, and year) May 18- 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing cutter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sonneborn & Sons

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Anton Scheder

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Theresa Stoffman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Ella Scheder
(Address) 507 S Washington St

15 Filed FEB 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1921, to Jan 29, 1923, that I last saw him alive on Jan 27, 1923, and that death occurred, on the date stated above, at 11.00 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 2 mos. 29 ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory -

(Signed) A L Tumbleson, M. D.

1/30 1923 (Address) 2013 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Feb 1 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St

Spec. 6-9-19—H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71849 D71849

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920 Harlem Ave ST. 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Krug

(a) RESIDENCE. NO. 1920 Harlem Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 4 mos. 30 ds. How long in U. S., if of foreign birth? Life mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or, WIFE of)~~ Mrs Marian L. Krug

6 DATE OF BIRTH (month, day, and year) Sept-1-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
#7	47	4	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Krug

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie G. Kohlman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Marian L. Krug
(Address) 1920 Harlem Ave

15 FEB 1 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-31-1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1922, to Jan 31, 1923, that I last saw him alive on Jan 30, 1923, and that death occurred, on the date stated above, at 12-45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) over 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No. What test confirmed diagnosis? Urinary Analysis + Physical Ex.

(Signed) Henry G. Philips, M. D.

Jan 31/1923 (Address) 1263 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	February 3rd 1923
20 UNDERTAKER	ADDRESS
Henry Storch Son	1301 E Eager St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71850

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D71850

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 McCulloh ST.; 11 WARD)

2-FULL NAME Martha Ennis

(a) RESIDENCE. No. 914 McCulloh ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 24 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	3	—	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Chas. Ennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Carrie Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Charles Ennis

(Address) 914 McCulloh St

15 FILED FEB 1 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 26 1923 to Jany 30 1923

that I last saw her alive on Jany 29 1923

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Ac. Entero-Colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Frank E Wagner M. D.

1923 (Address) 1176 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Laurel Burial

DATE OF BURIAL 2-1- 1923

20 UNDERTAKER David Easton

ADDRESS 916 Edmondson Ave

Spec.—1-10-21 M&J 1500 Bks.

D71851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D71851

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Parks

(a) RESIDENCE NO. 35 S. Washington St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1869 May 1st

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Cecelia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records.

(Address)

15 Filed FEB 1 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from January 25, 1923, to January 30, 1923, that I last saw him alive on January 29, 1923, and that death occurred, on the date stated above, at 5:15 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter Wheeler, M. D.

1/30/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laudon Park.

DATE OF BURIAL Feb 1st 1923

20 UNDERTAKER Wendel, Dippel & Son

ADDRESS 37 S. Linn

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71852

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. D71852

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1144 Sargeant St ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oliver C.F. Briggs

(a) RESIDENCE NO. 1144 Sargeant St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addie M.Grimes Briggs

6 DATE OF BIRTH (month, day, and year) December12,1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinst

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B &O R.R.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James Briggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bessie Bernitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Addie M Briggs.

(Address) 1144 Sargeant St.

15 FEB 1 - 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and ye JAN, 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 27- , 1923, to 1-30- , 1923.

that I last saw h alive on 1-30- , 1920,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteri Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Thos J Dreese, M. D.

, 19 (Address) 1227 Druid Park Dr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Febr y2. 1923.

20 UNDERTAKER John F. Conway & Son Chas F.J. Conway

ADDRESS 911 Hollins St

INSTRUCTIONS

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

Dr Sunville

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71853

CERTIFICATE OF DEATH.

118-00 V D71853

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 4824 Pimlico Road ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E G. Poe.

(a) RESIDENCE. No. 4824 Pimlico Road ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 86 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jacob Gans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mrt Knowe Jan 31, 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Mildred Graf

(Address) 452 N Pinehurst Rd

FEB 1 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1923, to Jan 30, 1923, that I last saw him alive on Jan 30, 1923, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Partial intestinal Obstruction from Adhesion Post-Operative

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) 66 years

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) A. Schmunk, M. D.

(Address) 4309 Liberty Hgts Jan 31, 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Feb 1 1923

20 UNDERTAKER ADDRESS

John O. Mitchell 1220 W. Fayette St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71854

100-001

CERTIFICATE OF DEATH.

D71854

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E Monument ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby boy Engleman

(a) RESIDENCE No. 3714 Towanda Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH" in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 26, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER Benj. Engleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elvina Jacobson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant J. Lewis
(Address) 1439 E. Bmca

15 FEB 1-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 26, 1923, to Jan 31, 1923, that I last saw h[illegible] alive on Jan 31, 1923, and that death occurred, on the date stated above, at 7 00 P m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Bright's disease (fatty degeneration of liver

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest Edlavitch, M. D.

2-1, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave.

DATE OF BURIAL Feb. 1 1923

20 UNDERTAKER Jack Lewis, 1439 E. Bmca

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D71855

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71855

CERTIFICATE OF DEATH.

11-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 N. First St Brooklyn ST., 6th WARD)

2-FULL NAME Clinton LeRoy Schneider

(a) RESIDENCE No. 223 N. First St. Brooklyn WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 19 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Susanna Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Louis Schneider (Address) 223 N First St Brooklyn

15 Filed FEB 1 - 1923 19... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 28, 1923, to Jany 31, 1923, that I last saw h[illegible] alive on Jany 31, 1923, and that death occurred, on the date stated above, at 6 10 P m.

The CAUSE OF DEATH was as follows: Congestion of Lungs

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) R. Leo Krauter M. D.

, 19 (Address) 1340 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL 2-1 1923

20 UNDERTAKER E & B Harle ADDRESS 115 E West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71856

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D71856

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Vine St, ST.: 18 WARD)

2-FULL NAME Lucy Duncan

(a) RESIDENCE. NO. 1013 - Vine ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. NAMES should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Williams

6 DATE OF BIRTH (month, day, and year) Dec 18, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33 years	1 mo.	12 ds.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Robert Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bettie Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Bottie Duncan
(Address) 1013 Vine St.

15 Date received FEB 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30. 23

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1922, to Jan. 30, 1923, that I last saw h[er] alive on Jan. 30, 1923 and that death occurred, on the date stated above, at 9:25 a. m.

The CAUSE OF DEATH* was as follows:

Necritis of Bronchial Pneumia

(duration) yrs. 1 mos. 18 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis A. Johnson, M. D.

, 19 (Address) 211-2-20 W. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Feb. 2, 1923
20 UNDERTAKER	ADDRESS
Mrs. Katie R. Williams	1114 W. Saratoga St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71857

CERTIFICATE OF DEATH.

107-003

D71857

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3231 Odonnel ST., 76 WARD)

2-FULL NAME Frank Pietrowski

(a) RESIDENCE NO. 3231 Odonnel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Julia Pietrowski

6 DATE OF BIRTH (month, day, and year) Oct 12 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) poland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) poland

14 Informant Mrs Julia Pietrowiak (Address) 3231 Odonnell ave

15 FEB 1 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1923, to Jan 30, 1923, that I last saw him alive on Jan 30, 1923, and that death occurred, on the date stated above, at 10 45 pm.

The CAUSE OF DEATH* was as follows:

Abscess Lung

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Colet Meier, M. D.

Jan 31 1923 (Address) 103 Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus — DATE OF BURIAL Feb 3 1923

20 UNDERTAKER John A Weber — ADDRESS 1803 Bank St

INSTRUCTIONS: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71858

CERTIFICATE OF DEATH.

3 D71858

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 Rosedale Av ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorathea M O'Brien

(a) RESIDENCE NO. 22 Rosedale Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William J O'Brien

6 DATE OF BIRTH (month, day, and year): May 1 1896

7 AGE: 26 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Jorge Merle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Helena Franke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: William J O'Brien

(Address): 22 Rosedale Ave

15 FEB 1 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 4, 1922, to Jan 31, 1923,

that I last saw her alive on Jan 30, 1923

and that death occurred, on the date stated above, at 4.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): acute dilatation of heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) Chas. Heyer, M. D.

2/1/1923 (Address) Hopkins Dispy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood burn — DATE OF BURIAL: Feb 2 1923

20 UNDERTAKER: George J Smith — ADDRESS: 1532 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfuiness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Nob S. B.
Cause unknown

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

D71859

CERTIFICATE OF DEATH.

REGISTERED NO. C D71859

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Fulton Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Harriet Enjay

(Residence in Baltimore: No. Home for Aged of the M. E. Church St.; ... yrs., ... mos. ... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Fem	White	Single

6-DATE OF BIRTH, Sept 22 (Month) (Day), 1853 (Year)

7-AGE, 69 yrs. 9 mos. 9 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nun
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Elijah Enjay

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Ann Dwyer

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Enjay

(Address) 400 N. Fulton Ave

15- FEB 1 - 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

Filed ..., 191...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jany (Month) 31 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 1922, to Jany 31 1923, that I saw her alive on Jany 30 1923, and that death occurred, on the date stated above, at 12 15 p m.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(Duration) ✓ yrs. ✓ mos. 10 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ✓ yrs. 3 mos. ✓ ds.

(Signed) George C. Shannon M. D.

2/1/23, 191... (Address) 400 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem	Feb 1, 191...
20-UNDERTAKER	ADDRESS
Geo J Smith	333 Holl

Spec.—1-10-21—M&T—1500 Bks.

D71860

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-01

D71860

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 Gough ST., 2 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Borowski

(a) RESIDENCE NO. 1805 Gough ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17-1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore.

(State or country) Md.

PARENTS

10 NAME OF FATHER John Borowski.

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Poland.

12 MAIDEN NAME OF MOTHER Antonina Kuczmeska.

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Poland.

14 Informant John Borowski

(Address) #1805 Gough St.

15 FEB 1 - 1923 ROBERT R. KINSTLER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 27 1923 to Jan 31 1923.

that I last saw her alive on Jan. 30 1923

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) ..... yrs. ..... mos 8 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) John H. Zehberger, M. D.

19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. Cem.

DATE OF BURIAL Feby 1. 1923.

20 UNDERTAKER M. F. Sadowski.

ADDRESS 705 S. Ann St.

IMPORTANT—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71861

D71861

146

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. ..... ST., 2 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Catherine Borowski

(a) RESIDENCE NO. 1726 Aliceanna ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ? yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Borowski,

6 DATE OF BIRTH (month, day, and year) September 24. 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	39	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, MD.

PARENTS

10 NAME OF FATHER John Piotrowisk,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Annie Koszlowski,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Peter Borowski, (Husband)

(Address) 1726 Aliceanna Street

15 Filed FEB 1-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1923, to Jan 30, 1923.

that I last saw her alive on Jan 30, 1923,

and that death occurred, on the date stated above, at 7-30 P m.

The CAUSE OF DEATH* was as follows:

Puerperal Endometritis

Retained Membranes

Septicemia — 3 weeks

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Broncho pneumonia 2-3 days

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Jan 27.

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. C. Rees, M. D.

, 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ST. STANISLAUS CEMETERY

DATE OF BURIAL Feb. 3. 1923.

20 UNDERTAKER M. J. Sadowski.

ADDRESS 705 S. Ann St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71862

CERTIFICATE OF DEATH.

74-001

D71862

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Johnson

(a) RESIDENCE NO. 405 Conway St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	72	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Eastern Shore, Maryland

PARENTS

10 NAME OF FATHER: Samuel Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Eastern Shore, Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Eastern Shore, Maryland

14 Informant: Municipal Hospital Records. (Address)

15 FEB 1-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 30 19 23

17

I HEREBY CERTIFY, That I attended deceased from January 27, 1923, to January 30, 1923, that I last saw him alive on January 30, 1923, and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) (Arteriosclerosis)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde O'Neill, M. D.

1/31/1923 Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion

DATE OF BURIAL: Feb 2 1923

20 UNDERTAKER: John N. Trader

ADDRESS 142 Uhler St

Spec.—1-10-21—M&T—1500 Bks.

D71863

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO. D71863

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Cooper

(a) RESIDENCE NO. 517 E 21st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick Cooper.

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE — Years: 47. Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: ? Waldron

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Patrick Cooper 517 E 21st St

15 Filed FEB 1 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1923, to Jan 31, 1923, that I last saw her alive on Jan 31, 1923, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia - Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) A. J. Smeaton M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem Govan — DATE OF BURIAL: Feb 5 1923

20 UNDERTAKER: E. A. Wedefind — ADDRESS: 501 E 25th

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY. AGE should be stated

Spec.—8-24-14—M. & T.—2000 Bks.

D71864

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71864

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 N. Streeper ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Varela

(Residence in Baltimore: No. 702 N. Streeper St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Infant

6-DATE OF BIRTH, Jan (Month) 25 (Day), 1923 (Year)

7-AGE, ...yrs. 6 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country), Balt.

PARENTS.

10-NAME OF FATHER, Joseph Varela

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Anna Stepanek

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Varela

(Address) 702 N. Streeper St

15- FEB 1 - 1923 1923 ROBERT H. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 31 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 27 1923, to Jan 31 1923, that I saw h alive on Jan 31 1923, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) William D. Kerr M. D.

Jan 31, 1923 (Address) 701 N. Howard St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Feb 1, 1923

20-UNDERTAKER Frank Brockton

ADDRESS 416 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71865

CERTIFICATE OF DEATH.

D71865

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2319 E. Monument St ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ABRAHAM BADERAC

(a) RESIDENCE NO. 2319 E Monument St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Chaim Baderac

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sophia Baderac

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 Eastern Ave

Filed FEB 1 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1st 1923

17

I HEREBY CERTIFY, That I attended deceased from March, 1918, to Jan 31, 1923,

that I last saw h alive on Jan 31, 1923,

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Schudeck, M. D.

, 19 (Address) 2378 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 2/1/23

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D71866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71866

CERTIFICATE OF DEATH.

139

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Eisenberg

(a) RESIDENCE NO. 2317 Penna. Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hiram Eisenberg

6 DATE OF BIRTH (month, day, and year) Nov. 12 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	10	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

837

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Adler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Minnie Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mercy Hospital Records

(Address)

15 Filed FEB 1 - 1923 ROBERT R. KRAUTER Clerk.

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1923, to Jan. 31, 1923

that I last saw her alive on Jan. 31, 1923

and that death occurred, on the date stated above, at 945 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Stom

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 1-19-23

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Operation

(Signed) D. J. Isaacson M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL Feb 19 23

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71867

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71867

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1538 N. Appleton ST., 15 WARD)

2-FULL NAME Sarah Bonner

(a) RESIDENCE NO. 1538 N Appleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Bonner

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 Baltimore

15 Filed FEB 1 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/31 1923

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1922, to Jan 30, 1923, that I last saw her alive on Jan. 30, 1923, and that death occurred, on the date stated above, at 6 00 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 5 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Whitehouse, M. D.

, 19 (Address) 1800 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrer Rosedale — DATE OF BURIAL 2/2 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

4706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71868

CERTIFICATE OF DEATH.

31 D71868

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 44 Rosekemp ave ST. 27 WARD)

2-FULL NAME Agnes E. Huber

(a) RESIDENCE NO 44 Rosekemp ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER William Huber

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Katherine Conner

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Kath. Huber
(Address) 44 Rosekemp ave

15 Filed FEB 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922 to Jan 30, 1923,

that I last saw her alive on Jan 30, 1923,

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion a Toxaemia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Bac. Sputum

(Signed) Chas Bruins, M. D.

1/31, 1923 (Address) 4702 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 2/2 1923

20 UNDERTAKER: J. J. Moran

ADDRESS 300 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state AGE should be stated EXACTLY. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D71869

D71869

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 19 Locust — St., St. Paul's Pay (Ward) 25

2-FULL NAME John G. Kirchenbauer

(a) RESIDENCE NO. 19 Locust St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Stanley M Kirchenbauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sadie Krueger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Sadie Kirchenbauer
(Address) 19 Locust St

15 Filed FEB 1 - 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 31 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1923, to Jan. 31, 1923, that I last saw him alive on Jan 30, 1923, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William P Lord, M. D.

, 19 (Address) 816 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Feb 2 1923

20 UNDERTAKER: Robt J Turner Sr

ADDRESS: 17 N. Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state AGE should be stated EXACTLY.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21 M&T 1500 Bks.

D71870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D71870

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma C. Shaw

(a) RESIDENCE NO. Westport, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William A. Shaw

6 DATE OF BIRTH (month, day, and year) Oct. 19 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	76	3-	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md. (State or country)

PARENTS

10 NAME OF FATHER George Rae

11 BIRTHPLACE OF FATHER (city or town) Balto., Md. (State or country)

12 MAIDEN NAME OF MOTHER Anna Catherine?

13 BIRTHPLACE OF MOTHER (city or town) U.S. (State or country)

14 Informant Elmer C. Shaw (Address) 858 W. Fayette St.

15 Filed FEB 1 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31 1923

17 I HEREBY CERTIFY, That I attended deceased from December 19, 1922 to January 31 1923.

that I last saw her alive on January 31, 1923.

and that death occurred, on the date stated above, at 12:10 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Refused

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

1/31/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Feb 3, 1923

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 N. Eutaw

Spec.—1-10-21—M&T—1500 Bks.

D71871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D71871

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3015 Cedar Ave ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Pauline Carlson

(a) RESIDENCE NO. 3015 Cedar Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 4-1922

7 AGE — Years: — Months: 8 Days: 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: August H. Carlson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kansas

12 MAIDEN NAME OF MOTHER: Myrtle V. Baldwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Laurel Maryland

14 Informant (Address): Mrs. August H. Carlson 3015 Cedar Ave

15 FEB 1 — 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/30 - 1923, to 1/31 1923.

that I last saw her alive on 1/31 1923

and that death occurred, on the date stated above, at 4 40 P.m.

The CAUSE OF DEATH* was as follows:

Thrombosis Coronary

Pulmonary Oedema

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination & Percussion

(Signed) Edna F. Kelly, M. D.

1923 (Address) 3705 Fait Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel, Md. DATE OF BURIAL: Feb 2 1923

UNDERTAKER: Horace H. Burgee ADDRESS: 3631 Falls Rd.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71872
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME William Schaeffer

(a) RESIDENCE NO. Chesapeake City, Cecil Co. Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marie Schaeffer

6 DATE OF BIRTH (month, day, and year): May 27th 1889

7 AGE: Years 33 Months 8 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): 109

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mary Land

PARENTS

10 NAME OF FATHER: Joseph Schaeffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mary Land

12 MAIDEN NAME OF MOTHER: Winifred Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mary Land

14 Informant (Address): Hospital Record

15 FEE: FEB 1 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1923 to Jan. 31, 1923

that I last saw him alive on Jan 31, 1923

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Subacute Endocarditis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Pneumonia, regeal o dema 6 hrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Signs

(Signed) J. [illegible], M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elkton Md.

DATE OF BURIAL: Feb. 1 1923

UNDERTAKER: Horace H. Burgee

ADDRESS: 363 Stalls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71873 HEALTH DEPARTMENT—CITY OF BALTIMORE D71873

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 835 Willow ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo F. Keller

(a) RESIDENCE NO. 835 Willow ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 4 - 1870

7 AGE: Years 52 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Geo A Keller,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Elizabeth Nugent

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Mabel Keller 835 Willow St

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

1-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1922, to Jan 30, 1923, that I last saw him alive on Jan 30 1923, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

6 mos

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John F. Keller M. D.

Jan 30 1923 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL 2/2 1923

20 UNDERTAKER: H. G. Wadefield 914 Drummond Ave

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71874 D71874

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 Ausquith St., 9 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert E. Stevenson

(a) RESIDENCE No. 1812 Ausquith St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Ma	Wh	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) March 4, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk in Grocery

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) .....

PARENTS

10 NAME OF FATHER James E. Stevenson

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) .....

12 MAIDEN NAME OF MOTHER Bessie Jacobs

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country) .....

14 Informant Jas E. Stevenson (Address) 1812 Ausquith

15 (Date) Jan 31 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1922, to January 31, 1923.

that I last saw him alive on January 30, 1923,

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis +

Exhaustion

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Phthisis

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Laboratory

(Signed) C. O. Carman, M. D.

1-31, 1923 (Address) 1701 N. Carlin st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	Feb 4 1923

20 UNDERTAKER Zirkler & Zirkler ADDRESS 1737 Eager

1-1923

George Arnold Ely ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71875 HEALTH DEPARTMENT—CITY OF BALTIMORE D71875

89

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 E. [illegible] Ave., St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Arnold Ely

(a) RESIDENCE. No. 322 E. [illegible] Ave., St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily Ely

6 DATE OF BIRTH (month, day, and year) May 11. 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Piano Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER George A. Ely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Ely (Address) [illegible] Glenvale

15 1-31-1923 19 Robert F. Haynes, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from December 16, 1922, to January 30, 1923, that I last saw him alive on January 30, 1923, and that death occurred, on the date stated above, at 3 PM m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Angina pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw 2 Pelton, M. D.

2/1, 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	2/2 19
20 UNDERTAKER Mary H. Mitake	ADDRESS 5214 Harford St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D71876

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Hollins St. ST. 19 WARD)

REGISTERED No. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Thomas Smith

(Residence in Baltimore: No. 1506 Hollins St.; 63 yrs. 7 mon. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June 27, 1859
(Month) (Day) (Year)

7-AGE, 63 yrs. 7 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): N/C

9-BIRTHPLACE, (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, Mathew Smith

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Margaret O'Brien

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel H. Smith

(Address) 1506 Hollins St.

15- Filed 1923, 191.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan. 31, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1923, to Jan 31. 1923, that I saw h[illegible] alive on Jan 31. 1923 and that death occurred, on the date stated above, at 830 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (Duration) 1 yrs. mos. ds.

(Signed) Edgar L. Mowers M. D.

Jan 31, 1923. (Address) 1520 Bolton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem.

DATE OF BURIAL, Feb 3, 1923

20-UNDERTAKER Harry N. Witzke

ADDRESS 1531 N. Lombard

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71877 HEALTH DEPARTMENT—CITY OF BALTIMORE D71877

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 S. Kenwood Ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Adolph Kleiner.

(a) RESIDENCE NO. 516 S. Kenwood ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER August A. Kleiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Sophia Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) August Adolph Kleiner 516 S. Kenwood ave

15 1-1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30th 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-20, 1923; to Jan 30, 1923.

that I last saw him alive on Jan 30, 1923,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 715 S Lakewood

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) CA Reifschneider, M. D.

1-31, 1923 (Address) 2939 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: Feb. 2nd 1923

20 UNDERTAKER: Lilly & Zeller ADDRESS: 403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71878

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71878

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103. W. Lanvale ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Johnson

(a) RESIDENCE NO. 103. W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 10 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73.	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Balto C. Md.

PARENTS

10 NAME OF FATHER Michael Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary Blockdell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant Mary Johnson

(Address) 1008 N. McDonough St

1 — 1923 Jan 3, 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31st 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1923, to Jan 31st, 1923, that I last saw her alive on Jan 31st, 1923, and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

(Arteriosclerosis) Nephritis.
Cyanosis (Hypostatic Pneumonia)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cyanosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) C B Gamewell, M. D.

, 19 (Address) 24 N Bidde

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 3 1923

20 UNDERTAKER Geo W Fink & Son

ADDRESS 877 W Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71879 D71879

CERTIFICATE OF DEATH.

23

1-PLACE OF DEATH Hospital for the Women of Md

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME Sallie Owings Forman

(a) RESIDENCE NO. 109 E. Lafayette Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Albert Forman

6 DATE OF BIRTH (month, day, and year) Aug 20th 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Housework 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Wm B. Owings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard co. md.

12 MAIDEN NAME OF MOTHER Eleanor Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard co. Md.

14 Informant Mr Albert Forman

(Address) 109 E Lafayette Ave

15 Filed 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1923, to Feb 1, 1923, that I last saw h.er alive on Feb 1, 1923, and that death occurred, on the date stated above, at 8:45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Encephalitis Lethargica

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) Norman E Tannenbaum, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL Feb 2nd 1923.

UNDERTAKER A.M. Perkins & Son-Inc ADDRESS Orchard & Collington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71880

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D71880

1 PLACE OF DEATH — REGISTERED No. C.....

CITY OF BALTIMORE (No. 909 Dukeland St. St. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME George William Bottinger

(Residence in Baltimore: No. 909 Dukeland St St.; 89 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Sept (Month) 16 (Day), 1833 (Year)

7 AGE: 89 yrs. 5 mos. 15 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas de Courcelle

(Address) 909 Dukeland St

15. Robert F. Harris,

....., 191.

Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 31st (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28th, 1923, to Jan 31st 1923; that I saw h.. alive on Jan 31st, 1923; and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Cardiac Failure

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Herbert E. Zepp M. D.

Feb 1st, 1923 (Address) 3048 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Greenmount Cem — DATE OF BURIAL: Feb 2, 1923

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

- 1923

HEALTH DEPARTMENT--CITY OF BALTIMORE

D71881

CERTIFICATE OF DEATH

129

D71881

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1124 W. Lafayette Ave St. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Susanna C. Condon

(Residence in Baltimore: No. 1124 W. Lafayette Ave St.; 11 yrs. mos. ds.)

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: September 8, 1835 (Month) (Day), 1 (Year)

7 AGE: 87 yrs. 4 mos. 23 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: At home.
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Caleb Kelly

11 BIRTHPLACE OF FATHER (State or country): A.A.Co. Maryland

12 MAIDEN NAME OF MOTHER: Katherine Walters

13 BIRTHPLACE OF MOTHER (State or country): Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. S.S.Smith,

(Address) 1122 W. Lafayette Ave.

15 Robert P. Harrison,

Filed ..... 191 ..... Burial Permit Clerk. REGISTRAR

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan 31 (Month) (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Jan 31 1923, that I saw h[illegible] alive on Jan 30, 1923, and that death occurred, on the date stated above, at 1.23 6 m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(Duration) 15 yrs. mos. ds

Contributory (SECONDARY) (Duration) mos. ds.

(Signed) Vernon N. Condon M.D.

Feb 1, 1923 (Address) 750 N. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Feb. 2nd 1923

20 UNDERTAKER: John O. Mitchell

ADDRESS: 1201 W. Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71882

CERTIFICATE OF DEATH.

11-001

D71882

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 W. Lexington ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Elizabeth Chambers

(a) RESIDENCE NO. 1616 N. Fenwick ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan. 1-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Martin Rice

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Perdella Chambers

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Helen E. Chambers

(Address) 1616 W. Lexington St.

15 Filed 19

Robert P. Carrison, Burial Permit Clerk. Registrar

1 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 30 1923, to 19, that I last saw h[illegible] alive on Jan. 30, 1923 and that death occurred, on the date stated above, at 3 A.M. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Lagrippe

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) James M. Hyer, M. D.

, 19 (Address) 1046 Pennsylvania Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Feb 2 1923

20 UNDERTAKER Brauer & Freeland. ADDRESS 1404 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71883

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D71883

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Washington Blvd. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theo. Smith

(a) RESIDENCE. No. 628 Wash. Blvd. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 26 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Ina A. Walter

6 DATE OF BIRTH (month, day, and year): Dec 5 = 1864

7 AGE: Years 60 Months 1 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Theo. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Earl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Ina A. Smith (Address) 628 Washington Blvd

15 FEB 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 31, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1923, to Jan. 31, 1923, that I last saw h.. alive on Jan. 30, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) Harry L Brook, M. D.

Feb. 1, 1923 (Address) 602 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Feb 3/23
20 UNDERTAKER	ADDRESS
A. B. Kuppert	223 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. WOMEN should state

D71884

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71884

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl O. Schultheis

(Residence in Baltimore: No. 2526 Boyd St.; yrs., mos., ds.)

188-009

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March (Month) 4 (Day) 1915 (Year)

7-AGE, 7 yrs. 10 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto City

PARENTS:

10-NAME OF FATHER, Henry Schultheis

11-BIRTHPLACE OF FATHER, (State or Country). Balto, Md.

12-MAIDEN NAME OF MOTHER, Lena Koenig

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Schultheis

(Address) 2526 Boyd St.

15-

FEB 2 - 1923

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 31 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Base of Skull and Accident, I was Coasting down Hill & Ran into Automobile

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage and Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James W. Fenton M. D. (Coroner)

Feb 2 1923 (Address) 710 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Hollins & Catherine Sts

Former or usual residence 2526 Boyd St.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, Feb 3 1923

20-UNDERTAKER, J. B. Hupfeld ADDRESS 2336 Fred'k Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71885

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D71885

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1925 ST., Patterson Place WARD 8)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Hornstein

(a) RESIDENCE NO. 1925 ST., Patterson Place WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of wife

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	/	/	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Roumania

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) Roumania

12 MAIDEN NAME OF MOTHER Mollie Hidushka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Roumania

14 Informant Hyman Hornstein

(Address) 1925 Patterson Place

15 FEB 2 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1st, 1923, to February 1st, 1923, that I last saw her alive on February 1st, 1923, and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel Silverstein M. D.

, 19 (Address) 22 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel DATE OF BURIAL Feb-2 1923

20 UNDERTAKER Just Funl ADDRESS 1439 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71886

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D71886

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 W. North ave ST. 14 WARD)

2-FULL NAME ROA BURKA

(a) RESIDENCE NO. 1217 W. North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state ... AGE should be stated EXACTLY. ... Typewriting supplied.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Meyer Burka

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE — Years: 55 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis (Address): 1439 E. Baltimore St

15 FEB 2 - 1923 ROBERT R. KNAUER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/30 1923

17 I HEREBY CERTIFY, That I attended deceased from 7/1, 1922, to 1/30, 1923, that I last saw her alive on 1/30, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypothyroidism. Chr. myocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Zozinberg, M. D.

1/30 1923 (Address) 1802 E. Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Veterans Rum — DATE OF BURIAL: 2/2 1923

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E. Balto St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71887

CERTIFICATE OF DEATH.

23

D71887

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Falek

(a) RESIDENCE NO. 207 S. Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Rafael Falek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Yunick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1439 E Balto St

15 Filed FEB 2 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1923, to Feb. 1, 1923, that I last saw her alive on Feb. 1, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(duration) yrs. mos 25 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Isidor Irwin Fry M. D.

2/1, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 2/2 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec. 6-9-19—H. P. Co.—1000 Blks.

Shuller

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71888

CERTIFICATE OF DEATH.

101-00

D71888

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 809 Roch alley ST. 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Shuller

(a) RESIDENCE. No. 809 Roch al ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): ~~Married~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Unknown~~

6 DATE OF BIRTH (month, day, and year) Unknown 1891

7 AGE: Years 32 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Samuel Shuller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Hannie Elder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys Co Md

11 Informant: Mary Shuller

(Address) 809 Roch alley

15 Filed FEB 2 - 1923 ROBERT R. KRAUSER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/30/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/17/23, 19..., to 1/30/23, 19..., that I last saw h... alive on 1/29/23, 19..., and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis liver

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Finley Wiley, M. D.

2/1/ 1923 (Address) 1958 Thorpe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL 2/2 1923

20 UNDERTAKER: Samuel T. Hensley

ADDRESS 878 N Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71889

CERTIFICATE OF DEATH.

31 D71889

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Warner

(a) RESIDENCE NO. 2802 N. 28th st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) N.T.H.

15 Filed FEB 2 - 1923 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31, 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1922, to Jan. 31, 1923, that I last saw him alive on Jan. 31, 1923, and that death occurred, on the date stated above, at 3.20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Badaglicco M. D.

1-31, 1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Feb 3 1923

20 UNDERTAKER Samuel T. Demuth

ADDRESS 578 Middle

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71890

D71890

105

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 658 Raborg ST., 4 WARD)

2-FULL NAME Lillian Lee

(a) RESIDENCE NO. 658 Raborg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Lee

6 DATE OF BIRTH (month, day, and year): Unknown 1892

7 AGE: Years 31 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: George Hall

(Address): 10 Saratoga Court

15 Filed FEB 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 31 1923

17 I HEREBY CERTIFY, That I attended deceased from June 3 1922 to Jany 31 1923.

that I last saw her alive on Jany 30th 1923,

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

Emphysema (Duration) Indeterminate

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. S. Howell M. D.

2/3/1923 Address) 1194 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M & Cemetery

DATE OF BURIAL: 2/5 1923

20 UNDERTAKER: Samuel J. Kennedy & Riddle

ADDRESS 678

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No Tuberculosis

D71891

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D71891

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE, (No. University Hospital St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Harris

(Residence in Baltimore: No. 900 Leadenhall St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Col.	Sgle

6-DATE OF BIRTH. Dont Know ....., 1..... (Month) (Day) (Year)

7-AGE. 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Carpenter
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER, (State or Country). - -

12-MAIDEN NAME OF MOTHER, - -

13-BIRTHPLACE OF MOTHER, (State or Country). - -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mc Boyce

(Address) 108 W Montgomery

FEB 2 - 1923

Filed ..... 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 30 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or Inquiry.) find that said deceased came to h.s.o. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

.....(Duration) ..... yrs. Dont Know mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Journal M. D. (Coroner.)

2-1 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet	2.2.1 19.23
20-UNDERTAKER.	ADDRESS
R L Packard	220 N Paca

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D71892

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71892

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 S Sharp St. ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth J. Roby.

(a) RESIDENCE NO. 1006 S. Sharp St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widow.

5a If married, widowed, or divorced

(a) HUSBAND of

(b) WIFE of Charles J. Roby.

6 DATE OF BIRTH (month, day, and year) December 15, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William R. Tumblinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Margaret Parson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant William V. Roby, (son)

(Address) 1006 S. Sharp St.

15 Filed FEB 2 - 1923, 19 .... ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 30 19 23.

17 I HEREBY CERTIFY, That I attended deceased from Jany 26th., 19 23., to Jany 30th., 19 23.

that I last saw her alive on January 29th., 19 23

and that death occurred, on the date stated above, at 8. 30 ♄ m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Apnoea.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ------

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diag.

(Signed) Carl Reinhardt M. D.

2/1, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL Feb. 2 1923

20 UNDERTAKER Mrs. E. Evans & Son ADDRESS 1428 E. Chas St

Spec.—1-10-21—M&T—1500 Blks. D71893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D71893

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hosp ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Louise Nelson

(a) RESIDENCE NO. 1525 Jackson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Aug. 21, 1861.

7 AGE — Years: 61 Months: 5 Days: 9 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home-Work

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: M. Lambert

(Address): 1525 Jackson St

15 FEB 2 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 31 1923

17 I HEREBY CERTIFY, That I attended deceased from January 25 1923 to January 31 1923 that I last saw her alive on January 31 1923, and that death occurred, on the date stated above, at 9 45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) John A. O'Connor, M. D.

, 19 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 2/1/1923

20 UNDERTAKER: E. J. Fanning — ADDRESS: Don-1460 Battery Av.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

D71894

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71894

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 644 W. Fayette St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Chas H Stone

(Residence in Baltimore: No. 644 W. Fayette St; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Divorced

6-DATE OF BIRTH. July (Month) (Day) 1877 (Year)

7-AGE. 45 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Wm Stone

11-BIRTHPLACE OF FATHER, (State or Country) England

12-MAIDEN NAME OF MOTHER. Maria Enderby

13-BIRTHPLACE OF MOTHER, (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Polzak

(Address) 3016 Harford Rd

15- FILED FEB 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 31 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or)~~ Inquiry.) thereon and from the evidence obtained by said ~~(Inquest, au-~~ topsy or inquiry.) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Inhalation of illuminating Gas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Suicide

~~(Duration)~~ yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

1/31 1923 (Address) 10 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery — DATE OF BURIAL, 1/2/ 1923

20-UNDERTAKER, E J Fanning & Son — ADDRESS 1938 E Lafayette Ave.

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should

D71895

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71895

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 Orleans ST.: 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Freeman Brown

(a) RESIDENCE. NO. 1304 Orleans ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Sarah Brown.

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3y	3m	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer None Particularly

9 BIRTHPLACE (city or town) (State or country) Telford Co. N. C.

PARENTS

10 NAME OF FATHER Wes Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Severia Freeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Leo. O. Brown (Address) 1304 Orleans St.

15 Filed FEB 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 30 Jan 1923

17 I HEREBY CERTIFY, That I attended deceased from 20 Jan. 1923 to 30 Jan. 1923 that I last saw h[illegible] alive on 29 Jan. 1923 and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

3 Pleurisy

New Hampshire

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Suspected

(Signed) Mayfield Boyle, M. D.

30/1 1923 (Address) 425 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	Feb 3. 1923
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1728 Ashland Ave

D71896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179

Registered No. D71896

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Viola Johnson

(Residence in Baltimore: No. 1033 Druid ave St. Pk yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col.

5-Single, Married, Widowed, or Divorced. (Write the word.): Mar'd

6-DATE OF BIRTH: July (Month) 4 (Day) 1894 (Year)

7-AGE: 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Edw. Fletcher

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Alberta Thompson

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed. Fletcher

(Address) Crondonsville md

15- Filed FEB 2 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 30 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or)~~ Inquiry.) thereon and from the evidence obtained by said ~~(Inquest, or Inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Severe burns on body

2 hrs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) accidentally caught fire from open stove

(Duration) yrs. mos. ds.

(Signed) H K Grossnickle M. D.
(Coroner.)

1/31 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Westview Star Cemetery — DATE OF BURIAL: February 1 1923

20-UNDERTAKER: Catonsville — ADDRESS: 1735 Cleveland Ave

Mrs Robert A Elliott

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71897 CERTIFICATE OF DEATH. 101-001 D71897

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Pennington Ave. | 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan C. Collins -

(a) RESIDENCE. No. 712 Pennington Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life. yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 11-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher, Teachers training school -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Ch. Joseph H. Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) in unknown a New England State

12 MAIDEN NAME OF MOTHER Emeline Hamblin

13 BIRTHPLACE OF MOTHER (city or town) Boston. (State or country) Mass.

14 Informant (Address) J. Ward Minner. 2125 Maryland Ave

15 Filed FEB 2 - 1923 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31-1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26- 1923, to Jan. 31- 1923

that I last saw her alive on Jan. 31- 1923

and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows: Influenza, Lobar Pneumonia (double)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? clinical exam -

(Signed) J. Ward Minner. M. D.

1/31 1923 (Address) 2125 Marylandave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb 3 1923

20 UNDERTAKER Margaret D. Flynn ADDRESS 1422 Light St.

MEDICAL CERTIFICATE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71898

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71898

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 William ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Mulkern

(a) RESIDENCE. NO. 1223 William ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29, 1881

7 AGE: Years 41 | Months 6 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Bernard Mulkern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Moran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Mulkern (Address) 1223 William St.

15 Filed ..... 19..... (Registrar)

FEB 2 - 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/1 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 30, 1923, to Feb 1, 1923,

that I last saw h alive on Jan 31, 1923,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) – Chronic Rheumatism

(duration) 6 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Whitelo, M. D.

Feb, 1923 (Address) 1271 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cem.

DATE OF BURIAL: Feb. 5 1923

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1417 Light St.

D71899

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181-001

D71899

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2325 W. Northave. St., 15 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henry Gunther

(Residence in Baltimore: No. 2325 W. Northave. St.; 62 yrs., 0 mos., 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Single

6-DATE OF BIRTH. June (Month) 23 (Day) 1861 (Year)

7-AGE. 62 yrs. 0 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Butter + Egg
(b) General nature of industry, business, or establishment in which employed (or employer). Merchant

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John Gunther

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Heiner

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs James H. Ringgold

(Address) 2325 West Northave

15-

Filed FEB 2 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 30 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

asphyxiation by gas (accidental)

Aluminiating gas fitter

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Acute alcoholism

(Duration) ....yrs. ....mos. 1 ds.

(Signed) J. T. Hennessy M. D.

(Coroner.)

Feb 1, 1923 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery DATE OF BURIAL, 2/2/ 1923

20-UNDERTAKER, Geo. Weber & Son ADDRESS 2503 Edmondson

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D71900

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001

D71900

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 822 Powers ST., (or) 13 WARD)

2-FULL NAME Donald L Thompson

(a) RESIDENCE NO. 822 Powers ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb 21 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Louis E Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mildred Mullinix

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Louis E Thompson (Address) 822 Powers St

15 FILED FEB 2 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1923 to Jan. 24. 1923

that I last saw h[illegible]live on Jan 23, 1923

and that death occurred, on the date stated above, at 1145 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Bronchopneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Lagrippe

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. Templeman, M. D.

19 (Address) 3701 Dorf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Feb 2 1923
20 UNDERTAKER	ADDRESS
Chenowith & Son	Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

D71901

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71901

CERTIFICATE OF DEATH.

100-001

6

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 N. Belnord Ave ST., WARD)

2-FULL NAME Margerit Jessup

(a) RESIDENCE NO. 117 N Belnord Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state carefully, supplied.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 5 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ———

(b) General nature of industry, business, or establishment in which employed (or employer): ———

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Howard Jessup

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Pearl Imeads

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: George Imeads

(Address) 532 N. Bunnord Ave

15 Filed FEB 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-31 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-28, 1923, to 1-31, 1923

that I last saw h- M- alive on 1-31, 1923,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Fred Thomas M. D.

(Address) 80 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Feb 3 1923

20 UNDERTAKER: Geo C. Miller — ADDRESS: 2334 Jefferson St

Spec.—1-10-21—M&T—1500 Bks.

D71902

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-601 D71902

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 Woodbourne Av ST., 27 WARD)

2-FULL NAME Edith Beatrice Davis.

(a) RESIDENCE NO. 622 Woodbourne Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 4th 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Baltimore

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Emma Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Emma Davis
(Address) 622 Woodbourne Ave

15 Filed FEB 2 - 1923 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31st 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 20th, 1923, to Jan 31st, 1923, that I last saw her alive on Jan 31st, 1923 and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Greenleaf Miller Jr M. D.

1/31/1923 (Address) 40 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Feby 8 1923

20 UNDERTAKER John Merrick — ADDRESS 228 E Preston

Spec.—1-10-21—M&T—1500 Bks.

D71903 HEALTH DEPARTMENT—CITY OF BALTIMORE D71903

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 N Milton Ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine F Bien

(a) RESIDENCE NO. 1026 N Milton Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Bien

6 DATE OF BIRTH (month, day, and year): June 20 1870

7 AGE: Years 52 Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Australia

PARENTS

10 NAME OF FATHER: Martin Dreyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr William Christoph Son

(Address) 1026 N Milton Ave

15 Filed FEB 2 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 , 19 22 to Jan 30 , 19 23

that I last saw her alive on Jan 28 , 19 23

and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 4 mos. d.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Supposed

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fred Rupp Jr M. D.

Feb 1 , 1923 (Address) 50 Overdale Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: Feby 3 1923

20 UNDERTAKER: John Sullivan

ADDRESS: 200 Aliceanna

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71904 — CERTIFICATE OF DEATH

90 D71904 Registered No. C.....

City of BALTIMORE: (No. 1633 N. Bond St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Opitz

(Residence in Baltimore: No. 1633 N. Bond St.; yrs. 45 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. March 4, 1852
(Month) (Day) (Year)

7-AGE. 70 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Book Binder

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernst C. Opitz Son

(Address) 1633 N. Bond

15- Filed FEB 2 - 1923, 192.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 31, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes - Probably Senile Decline

Injuries received in fall and other dressing at home (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Wm. Walter M. D.
(Coroner.)

2-1st, 1923. (Address) 508 E. Stricker

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Feby 2 1923
20-UNDERTAKER, John Dellrich	ADDRESS 208 S. Eden

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71905

CERTIFICATE OF DEATH.

74-001 D71905

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2753 Riggs Ave. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Griffin

(a) RESIDENCE NO. 2753 Riggs Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69.	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.

PARENTS

10 NAME OF FATHER James Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Prather

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Loretta Pilson

(Address) 1800 W. Balto. St.

15 Filed FEB 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from January 30, 1923, to January 31, 1923,

that I last saw him alive on January 31, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arteria sclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemmorrage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Cookham, M. D.

2/1, 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 2 - 3 - 1923

20 UNDERTAKER H. C. Brenninger Son

ADDRESS 311 North Schroeder St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71906

CERTIFICATE OF DEATH.

100-001

D71906
REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 864 W. Lombard St. ST., 18 WARD)

2-FULL NAME John J. Hyland

(a) RESIDENCE NO. 864 W. Lombard St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 19, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas G Hyland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Healey Hyland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Alice Healey Hyland
(Address) 864 W. Lombard St.

15 Filed FEB 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febry 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1923, to Feb. 1, 1923, that I last saw h— alive on Feb. 1, 1923, and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchs - pneumonia

(duration) 2 yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Convulsions,

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) John Thornton, M. D.

(Address) 888 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cemetery — DATE OF BURIAL: Febry 3 1923

20 UNDERTAKER: John F. Cowan & Son, Per F. J. Cowan — ADDRESS: 901 Hollins St.

DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

65-001

D71907

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH D71907

CITY OF BALTIMORE: (No.) 1014 Potomac ST., 6 WARD)

2-FULL NAME John A. Goeffner Jr

(a) RESIDENCE No. 1014 Potomac ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30 1910

7 AGE — Years: 12 — Months: 4 — Days: — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John A. Goeffner

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Kathr Noll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant (Address): John A. Goeffner 1014 N. Potomac

15 FEB 2 - 1923 ROBERT R. KRAUSER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23 '23 to Jan 30 '23.

that I last saw him alive on Jan 30, 1923,

and that death occurred, on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:

Haemorrhages.

Spleno Lymphatic Leukaemia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood picture

(Signed) Kirk Insley, M. D.

'23 (Address) 2938 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery

DATE OF BURIAL: 2/2 1922

20 UNDERTAKER: John A Moran

ADDRESS: 3000 E Balto St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71908 ✓ 90 D71908

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH D71908

CITY OF BALTIMORE (No. 5011 Liberty Heights Ave ST., 28 WARD)

2-FULL NAME Sarah V. Johnson

(a) RESIDENCE NO. 5011 Liberty Heights Ave ST., ... WARD 1

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Born yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Halliard Johnson

6 DATE OF BIRTH (month, day, and year): Oct. 2-1840

7 AGE — Years: 82 | Months: 2 | Days: 29 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Rezin Appleby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Musgrove

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: George Johnson (Address) 5011 Liberty Heights Ave

15 Filed FEB 2 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1922 to Jan 31, 1923.

that I last saw h alive on Jan 31st, 1923,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 5 mos. ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) A. C. Smith, M. D.

Feb 1st 19 (Address) 4209 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Feb 3 1923

20 UNDERTAKER: A B Marshall — ADDRESS: 3539 Gall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71909

CERTIFICATE OF DEATH.

31 D71909

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ward

(a) RESIDENCE NO. 103 York st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Liza Jee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed FEB 2 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1923, to Feb. 1, 1923,

that I last saw him alive on Feb. 1, 1923,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Dalaglacca M. D.

2-1-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Ct — DATE OF BURIAL Feb 3 19

20 UNDERTAKER S. H. Brown & Son — ADDRESS 1638 Mosby

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

D71910 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71910

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 932 S. Sharp St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Smith. (C).

(Residence in Baltimore: No. 932 S. Sharp St. St.; yrs., mos., ds.)

-- 2 --

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	Colored.	Married.

6-DATE OF BIRTH, January 31st, 1878.
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
44 yrs. 11 mos. 30 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Virginia.

PARENTS.

10-NAME OF FATHER, Charles Baptist. (C)

11-BIRTHPLACE OF FATHER, (State or Country). Virginia.

12-MAIDEN NAME OF MOTHER, Ella Mills. (C).

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Smith. (C)(husband).

(Address) 932 S. Sharp St.

FEB 2 - 1923 Filed 192

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 30th, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto K. Reinhardt M. D.
(Coroner.)

Feb. 1st 1923. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Virginia

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cy DATE OF BURIAL, Feb 3 1923

20-UNDERTAKER. J. H. Brown's Son ADDRESS 1010 W. Baltimore St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D71911

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-006

D71911

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1924 N. Castle St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Lorraine Evans

(Residence in Baltimore: No. 1924 N. Castle St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Single

6-DATE OF BIRTH: May (Month) 20 (Day) 1922 (Year)

7-AGE: yrs. 8 mos. 20 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS:

10-NAME OF FATHER: Norman C. Evans

11-BIRTHPLACE OF FATHER, (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Eugenia Beanau

13-BIRTHPLACE OF MOTHER, (State or Country): New York

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Norman Evans

(Address) 1927 N. Castle

15-

Filed FEB 2 - 1923 192

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 31 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Death, — Acute Nephritis due to mercurial poisoning, — Inhalation of Mer. gases (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Culler M. D.
(Coroner.)

1-7 1923. (Address) 508 E. Lexington

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Feb. 3 1923

20-UNDERTAKER: H. Gander & Sons — ADDRESS: 1710 Fleet St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D71912

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D71912

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 524 W. Saratoga St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas D Cherry

(Residence in Baltimore: No. 524 W Saratoga St 30 St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH, Dont Know 1 (Month) (Day) (Year)

7-AGE. 35 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). 04 0

9-BIRTHPLACE, (State or Country). N. Carolina

PARENTS.

10-NAME OF FATHER. Hary Cherry

11-BIRTHPLACE OF FATHER, (State or Country). N. Carolina

12-MAIDEN NAME OF MOTHER. Mabel Bazemore

13-BIRTHPLACE OF MOTHER, (State or Country). N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Watson L. Cherry

(Address) Windsor N. C.

15- FEB 2 - 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 28, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or Inquiry.)~~ thereon and from the evidence obtained by said ~~Inquest, autopsy or Inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. Dont Know mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W K Tourtch M. D. (Coroner.)

2-2- 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Windsor N. C. DATE OF BURIAL. Feb 2 1923

20-UNDERTAKER. George T. A. Gibson ADDRESS 513 Lanvale St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71913

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

00-001 ✓

D71913

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3973 E. Pratt St. ST. No WARD)

2-FULL NAME Catherine Peterson

(a) RESIDENCE NO. 3973 E. Pratt St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 20-1922

7 AGE: Years — Months: 1 — Days: 4 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Allen Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Hannah Overby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Frederick Smith 3973 E. Pratt St.

15 FEB 2 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 31 1923

17 I HEREBY CERTIFY, That I attended deceased from January 29, 1923, 19..

that I last saw her alive on Jan 29, 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia (over)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Maxwell Lemmon M. D.

Feb. 1, 1923 (Address) 311 S Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: Feb. 7 1923.

20 UNDERTAKER: Lilly and Zeile

ADDRESS: 403 S. Wolfe St.

Make word or figure plainly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Broncho,
Primary,
No further history

Spec.—1-10-21—M&T—1500 Bks.

D71914

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D71914

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3307 Mueller St ST., 26 WARD)

2-FULL NAME Baby Adkins

(a) RESIDENCE NO. 3307 Mueller ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 31-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	—	6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Rufus Adkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Helen Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Anna Hilsz
(Address) 3307 Mueller St

15 FEB 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/31/23, 19..., to 2/1/23, 19...,
that I last saw him alive on 1/31/23, 19...,
and that death occurred, on the date stated above, at 1 A. M. p. m.

The CAUSE OF DEATH* was as follows:

Six months foetus

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Six months foetus

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. McConnell, M. D.

2/2/23 (Address) 600-S-3

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cem.

DATE OF BURIAL Feb 2 1923.

20 UNDERTAKER Lilly & Zeiler.

ADDRESS 403 Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71915

D71915

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 N. Chester ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Katherine Lewandowski,

(a) RESIDENCE NO. 1914 N. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 1870

7 AGE: Years 52 Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Frank J. Lewandowski (Address) 1914 North Chester St.

15 FEB 2-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 31, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922 to Jan 31, 1923, that I last saw h[illegible] alive on Jan 31, 1923, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 1 mos 12 ds.

CONTRIBUTORY (Secondary): Probably Cardiac

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

(Address) #14 S Bel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem., DATE OF BURIAL: Feby 3, 1923

20 UNDERTAKER: M. J. Sadowski ADDRESS: 701 S Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Nephritis

No other abnormal Conditions

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71916

CERTIFICATE OF DEATH.

90 D71916

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3401 Greenway Circle ST., 17 WARD)

2-FULL NAME Jennie Hoskins

(a) RESIDENCE NO. 3401 Greenway Circle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Sloan Hoskins

6 DATE OF BIRTH (month, day, and year) Jan. 25, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Christian Spamer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Elizabeth Schroeder

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant J. Sloan Hoskins

(Address) 3401 Greenway Circle

15 Date FEB 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31- 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1- 1923, to Jan. 31- 1923, that I last saw h[illegible] alive on Jan. 30- 1923 and that death occurred, on the date stated above, at 12:40a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Cardiac Hypertrophy.

about 20 (duration) yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) 2 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) [signature] M. D.

2/ 1923 (Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 2/2/23 19

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71917

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D71917

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Vogt.

(a) RESIDENCE NO. 5 N. Elmwood Ave, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of /

6 DATE OF BIRTH (month, day, and year): Aug 14, 1892

7 AGE — Years: 30 — Months: 5 — Days: 14 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chestertown Maryland.

PARENTS

10 NAME OF FATHER: Thos. Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent Co. Maryland.

12 MAIDEN NAME OF MOTHER: Mary Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co. Maryland

14 Informant: Elmer J. Vogt

(Address): 5 Elmwood Ave

15 Filed FEB 2 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 1 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1923, to Feb 1, 1923, that I last saw her alive on Feb 1, 1923 and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma (liver)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Nephritis Ch

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jno A Sampsonis, M. D.

, 19 (Address) Md Gen Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chestertown Md — DATE OF BURIAL: 2/3 1923

20 UNDERTAKER: Wm. Cook — ADDRESS: 5 E Northern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71918

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71918

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 920 Bevan St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Habermehl.

(Residence in Baltimore: No. 920 Bevan Street. St.; yrs., mos., ds.)

41

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH, January 17th, 1848.
(Month) (Day) (Year)

7-AGE, 75 yrs. -- 14 mos. ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Germany.

PARENTS.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caroline Habermehl. (wife).

(Address) 920 Bevan Street.

15-FILED FEB 2 - 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 31st, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer of the Kidneys.
Exhaustion.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner.)

Feb. 1st 1923. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Trinity Cem. DATE OF BURIAL. Feb 2nd 1923

20-UNDERTAKER. C. Schumann & Son ADDRESS 1034 Monument

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71919 D71919

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 19 WARD)

2-FULL NAME Mabel Parker

(a) RESIDENCE No. 1604 W. Mulberry st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	20 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Eden Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) M.T.H.

15 Filed FEB 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1922, to Feb. 1, 1923, that I last saw her alive on Feb. 1, 1923, and that death occurred, on the date stated above, at 3.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Theresa Pellegrino M. D.

2-1-23 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Feb. 3 1923
20 UNDERTAKER Jas. F. Dennis	ADDRESS 1203 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

INFORMANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71920

CERTIFICATE OF DEATH.

22 ✓

D71920

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 516 Rossiter Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Belzetta Worden

(Residence in Baltimore: No. 516 Rossiter Ave St.: 2 yrs., mos. 8 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sngle

6-DATE OF BIRTH, January 24, 1921 (Month) (Day) (Year)

7-AGE, 2 yrs. mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Andrew Worden

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Gertrude Clark

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs James F. Clark

(Address) 516 Rossiter Ave

15- Filed FEB 2 - 1923, 191... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 1, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 29 1923, to Feb. 1 1923, that I saw h.. alive on Feb 1 1923, and that death occurred, on the date stated above, at 5:10 P m.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia Paralysis

(Duration) ....yrs. ....mos. 1 ds.

(Signed) E. W. Bishop M. D.

Feb 1, 1923 (Address) 201 S Kenwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 2 yrs. mos. 8 ds. In the State 2 yrs. mos. 8 ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence Same

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, 2-2-, 1923

20-UNDERTAKER Wm Cook

ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D71921

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D71921

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Pennsylvania Ave ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Campbell

(a) RESIDENCE NO. 1114 Pennsylvania ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1, 1851

7 AGE Years 72 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Mr Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Sarah Isaac

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nate Campbell

(Address) 1114 Pennsylvania

15 Filed FEB 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1923, to Feb 1, 1923,

that I last saw her alive on Feb 1, 1923

and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumnia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Mitral disease of heart unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) William E Burton, M. D.

Feb 2 1923 (Address) 762 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Marys Hanover — DATE OF BURIAL 2/4 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71922

D71922

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 S Milton av. ST. 1 WARD)

2-FULL NAME Annie Schmeiser

(a) RESIDENCE NO. 626 S Milton ST. av WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 63. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Schmeiser

6 DATE OF BIRTH (month, day, and year): Dec. 12. 1840

7 AGE: 82 Years 1 Months 19 Days. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Kresser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Tilli Meisel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: George Schmeiser
(Address) 626 S Milton av.

15 Feb 2 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1923, to Jan 31, 1923, that I last saw h[illegible] alive on 1 24, 1923, and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. A Nelson, M. D.

2/2/1923 (Address) 408 S. Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: Feb 3 1923

20 UNDERTAKER: Louis Heemann — ADDRESS: 32 S Broadway

32—1923

BEFORE signing, be certain that ALL ITEMS have been answered and that no blanks remain. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Time of burial extended to Sunday

D71923 HEALTH DEPARTMENT—CITY OF BALTIMORE Feb. 4/23

CERTIFICATE OF DEATH D71923 Registered by Frederick J. Simpers Asst. Clerk

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 702 W. Lanvale ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Sheridan

(a) RESIDENCE. No. 702 W. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C.	Married ~~Widower~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Sheridan

6 DATE OF BIRTH (month, day, and year) Feb. 26 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50	-	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore md.

PARENTS

10 NAME OF FATHER Chas. Sheridan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore md.

12 MAIDEN NAME OF MOTHER Amelia Johns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nellie Sheridan (wife) (Address) 702 W. Lanvale St.

15 Filed Feb 2 1923 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan-1- 1923 to Jan. 30- 1923

that I last saw h.er alive on Jan 30 - 1923,

and that death occurred, on the date stated above, at 6 30 p m.

The CAUSE OF DEATH* was as follows:

Acute Corenchymatous Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. B. Snyder M. D.

Feb 2 1923 (Address) 1413 E. Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Carmel Cem Feb 4 1923

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1724 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2-1923

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71924

CERTIFICATE OF DEATH.

124 D71924

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 N. Gay ST., 8 WARD)

2-FULL NAME Mary J. Stavely

(a) RESIDENCE No 1827 N. Gay st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 2 mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Thomas H. Stavely

6 DATE OF BIRTH (month, day, and year): Sept 23 1860

7 AGE: Years 62 | Months 4 | Days 9 | If LESS than 1 day, ... hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kent County Md

PARENTS

10 NAME OF FATHER: Richard Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent County Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent County Md

14 Informant: Roy S. Stavely

(Address): 2779 Glendale Ave

15 Filed ..... 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk.

2-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 18 1923 to Feby 1st 1923.

that I last saw her alive on Feby 1st 1923.

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 6 yrs. — mos ds.

CONTRIBUTORY (Secondary): Cardiac Failures.

(duration) ..... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Kirk M. D.

2/2/23 (Address) 3126 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Feb 3 1923

20 UNDERTAKER: Jos Joerdens & Son

ADDRESS: 2175 Pa...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71925 HEALTH DEPARTMENT—CITY OF BALTIMORE D71925

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1447 (Street) Riverside Ave (Ward) 24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edward Clark

(a) RESIDENCE. No. 1447 Riverside St., 24 Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. (40 minutes) mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 2.1.1923

7 AGE: Years — Months — Days — Lived 40 minutes. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Jno Edward Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Agnes Mascoffry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): John Edward Clark 1447 Riverside Ave

15 Filed: Robert P. Harrison, Registrar

2 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2.1. 1923

17 I HEREBY CERTIFY, That I attended deceased from 2.1. 1923, to 2.1. 1923, that I last saw him alive on 2.1 1923, and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Dystocia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uterine Fibroid

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. J. Turlington, M. D.

2.1.1923 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery

DATE OF BURIAL: Feb 2 1923

20 UNDERTAKER: James Dignan & Son

ADDRESS: 100 S. Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D71926 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D71926

CERTIFICATE OF DEATH. 129

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Ruxton Ave ST., 15 WARD)

2-FULL NAME Matilda Linstrom

(a) RESIDENCE NO. 1711 Ruxton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Frank O. Linstrom

6 DATE OF BIRTH (month, day, and year) May 30, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	68	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Gustav Hoglund

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Nim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Mrs. Emily K Wiese
(Address) 1711 Ruxton Ave

Filed Feb 2 1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1922 to July 1, 1923
that I last saw h[illegible] alive on July 1, 1923
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Renal
Coronar Collapse

(duration) yrs. 7 mos 4 ds.

CONTRIBUTORY (Secondary) Cardio Renal Disease

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Arthur L Tebbetts M. D.

7/1, 1923 (Address) 2836 Barrett

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL Feb 5 1923

20 UNDERTAKER W. J. Tickner & Sons

ADDRESS Mt Wash Pa

2— CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71927 D71927

CERTIFICATE OF DEATH.

REGISTERED NO. C. 74001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Ft Pleiskettles Factory 15 St.) 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaus Zanierski

(Residence in Baltimore: No. 1607 Shakespeare St. St.) 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec. 12th, 1875
(Month) (Day) (Year)

7-AGE. 47 yrs. 1 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Anthony Zaniewski

11-BIRTHPLACE OF FATHER (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Amelia Banowski

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophia Zaniewski

(Address) 1607 Shakespeare St.

15-

Filed ..... Robert P. Harrison, ...
Registrar.

2-1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 31st, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

Feb 2nd 1923 (Address) Curtis Bay, Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Feby 3rd 1923

20-UNDERTAKER J. Fialkowski

ADDRESS 428 E Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71928 HEALTH DEPARTMENT—CITY OF BALTIMORE D71928

11-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 E. 41st St.; 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Weber

(a) RESIDENCE. No. 814 E. 41st St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry F. Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jennie L. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Windsor Md

14 Informant Henry F. Weber (Address) 814 E. 41st St.

15 Filed Feb 3 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from January 20, 1923, to Feb. 1, 1923, that I last saw him alive on Jan. 31, 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Influenza Respiratory (duration) ....yrs. ....mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) F. H. Machen, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb. 3, 1923
20 UNDERTAKER E. LeRoy Stiffler	ADDRESS 125 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

2

D71929

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71929

CERTIFICATE OF DEATH.

1-PLACE OF DEATH ~~No~~ Mercy Hosp 9

Registered No. C.....

City of BALTIMORE: (No. ~~1102~~ ~~E Hoffman~~ St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~George~~ R Taylor

(Residence in Baltimore: No. 1102 E Hoffman St. ward 8

St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

6-DATE OF BIRTH, Jan 7 (Month) (Day) 1894 (Year)

7-AGE, 29 yrs. 1 mos. 26 ds. If LESS than 1 day, ... hrs. or ..... min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~Laborer~~ Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Do

9-BIRTHPLACE, (State or Country), Prince George Co. Md.

PARENTS.

10-NAME OF FATHER, George R Taylor

11-BIRTHPLACE OF FATHER, (State or Country), Prince George Co Md.

12-MAIDEN NAME OF MOTHER, Mary Taylor

13-BIRTHPLACE OF MOTHER, (State or Country), Prince George Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Taylor

(Address) 1102 E. Hoffman st.

15- Robert F. Harris, 192

2 - 1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 30 23

..... (Month) (Day) 192..... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held nn ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. skull - accidental
(Caused by horse running away)
Asses 3 w 4 mos

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchitis pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Feb 2 192 3 (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Holy Redeemer Cem. DATE OF BURIAL, Feb 3 1923

20-UNDERTAKER, Geo. J. Ruth ADDRESS 1735 Harford Ave.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71930 HEALTH DEPARTMENT—CITY OF BALTIMORE D71930

CERTIFICATE OF DEATH.

REGISTERED NO. 101-OD

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 727 Harvey ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wanda S Hepke

(a) RESIDENCE. No. 727 Harvey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov 22 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dressmaking

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Joseph Shepke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Lucille Mulcin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant: John Shepke (Address) 727 Harvey St

15 Filed 1923 Robert F. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-31-23.

17 I HEREBY CERTIFY, That I attended deceased from 1-23-23 19 to 1-31-23 19, that I last saw her alive on 1-31-23. 19, and that death occurred, on the date stated above, at 12.23 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac Dilitation acute

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Norris, M. D.

1-31-. 1923 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. DATE OF BURIAL: 2/1/23.

20 UNDERTAKER: G. J. Puth ADDRESS: 1155 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71931

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71931

CERTIFICATE OF DEATH.

109-00

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2302 E Fayette ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence E. Sheppard

(a) RESIDENCE. No. 2302 E. Fayette ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): June 22 1916

7 AGE: Years 6 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: J. Edgar Shppard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Gertrude Cault

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md

14 Informant (Address): J. E. Shppard 2302 E Fayette St

15 Filed: Feb 2 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 31 1923

17 I HEREBY CERTIFY, That I attended deceased from January 17. 1923. to January 31. 1923. (that I last saw him alive on January 31. 1923. And that death occurred, on the date stated above, at 715 P. m.

The CAUSE OF DEATH* was as follows:

Acute follicular tonsilitis and myocarditis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Acute cardiac dilatation 3 Hours.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Physical Examination

(Signed) Albert Rosenberg M. D.

(Address) 2027 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 2/3 1923

20 UNDERTAKER: John A Moran

ADDRESS: 3000 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2-1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71932

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71932

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Potomac Ave St. 25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Edgar Armiger Jr.

(a) RESIDENCE. No. 607 Potomac Ave St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER J. Edgar Armiger Sr.

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Augusta Burnsten

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mr J. Edgar Armiger Sr.
(Address) 607 Potomac Av.

15 Filed Robert P. Harrison, Registrar
2-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1923, to Feb 2, 1923, that I last saw h in alive on Feb 2, 1923, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas N Bonsola M. D.

19 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cem

DATE OF BURIAL 2/3 1923

20 UNDERTAKER J. Few McNally

ADDRESS Balto

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71933

CERTIFICATE OF DEATH.

D71933

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 16 WARD)

2-FULL NAME George W. Riggin

(a) RESIDENCE NO. 2831 Harlem ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) Aug. 1-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John T. Riggin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ruth Shaney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed 2-2 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1923 to Feb. 2, 1923, that I last saw h. im alive on Feb. 2, 23, and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute parotiditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Delaghacca M. D.

2-2-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL 2/5 1923

20 UNDERTAKER L. Frew Mc Cully

ADDRESS 130 E. Fort

FEB 2 1923

IMPORTANT—Items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D71934

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71934

CERTIFICATE OF DEATH.

11-00

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 N Wolfe ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Eihals

(Residence in Baltimore: No. 917 N Wolfe St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Nov (Month) 1 (Day) 1 (Year)

7-AGE, 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Joseph Jerpan

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Ant Moon

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos Eihals

(Address) 917 N Wolfe St

15-

Filed Jan 3 1923, by Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 31 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1923, to Jan 31 1923, that I saw h[illegible] alive on Jan 31 1923, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Cerebral

(Duration) yrs. mos. 1 ds.

(Signed) William H Grant M. D.

Feb 3, 1923 (Address) 1 W Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Feb. 3, 1923

20-UNDERTAKER Chas Knabe — ADDRESS 906 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

3-1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71935

D71935

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tina Klauti

(a) RESIDENCE NO. 602 Darley Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Klauti

6 DATE OF BIRTH (month, day, and year): June 15, 1878

7 AGE: Years 43; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Carl Haib

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Ahrns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Henry Klauti 602 Darley Ave

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

3-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1920, to Jan 31, 1923, that I last saw her alive on Jan 31, 1923 and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Parenchymatous Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): Uraemia Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uraemia

(Signed) Hubert E. Knapp, M. D.

, 19 (Address) 1216 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: July 3 1923

20 UNDERTAKER: Wilhelm & Hartt ADDRESS: 2126 E. Madt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Hydroy
Carroll Co Md

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71936

CERTIFICATE OF DEATH.

84 D71936

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 E. 28th St., 4 Ward)

2-FULL NAME John M- Diehl

(a) RESIDENCE NO. 1508- E- 28th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Diehl

6 DATE OF BIRTH (month, day, and year) July 13-

7 AGE Years 61 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant (Address) Anna M. Diehl 1508 E- 28th

15 Robert P. Harrison, M. D. Registrar

3-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1922, to Feb 1, 1923, that I last saw him alive on Feb 1, 1923, and that death occurred, on the date stated above, at 8.30 P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. L. Leary, M. D.

2/2, 1923 (Address) 6111 Reisterstown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lehmaier, Cemetery DATE OF BURIAL Feb 3 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E. North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See Instructions on back of certificates.

D71937

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71937

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 519 Eutaw St. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Margaret Stewart

(Residence in Baltimore: No. 519 Eutaw St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Col	Single

6-DATE OF BIRTH. Jan (Month) 8 (Day) 1923 (Year)

7-AGE. .....yrs. 2 mos. 2 wks ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balt City

PARENTS.

10-NAME OF FATHER. Edw Stewart

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Horace Stewart-

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw Stewart

(Address) 519 Eutaw

15- Robert P. Harrison, 192.....Registrar.

Burial Permit Clerk.

83-1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 1 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(~~Inquest, autopsy or inquiry.~~) thereon and from the evidence obtained by said.....(~~Inquest, autopsy or inquiry.~~) find that said deceased came to Feb 1 death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration).....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration).....yrs.....mos.....ds.

(Signed) H.R. Torsch M. D. (Coroner.)

2-2 1923 (Address) 117 N. Dakota St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn Cem	2-3 1923
20-UNDERTAKER.	ADDRESS
David Earley	916 Ea Lan

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

1/1329
D71938

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71938

32

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3 ST., 19 WARD)

2-FULL NAME Frederick Carter

(a) RESIDENCE NO. 503 N Bryce St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24, 919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Marshall Carter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Bertha Barber

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant ..... Records
(Address) JOHNS HOPKINS HOSPITAL

Filed ..... 19 ROBERT T. [illegible], Registrar

3-[illegible]-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1923, to Feb 1, 1923, that I last saw h/m alive on Feb. 1, 1923, and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 1 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore City

Did an operation precede death? ..... Date of no

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 2-3-1923

20 UNDERTAKER Daniel Carter

ADDRESS 9 N Eu 8a m

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71939

101-00 D71939

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 678 Pine Al ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alicia Larkins

(a) RESIDENCE. NO. 678 Pine Al ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col'd	Mar.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0/C

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Daniel Easton
(Address) 916 Pine

15 Filed 1923 Robert F. Harris, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH Feb 1-23

16 DATE OF DEATH (month, day, and year) March 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1923, to Feb 1, 1923, that I last saw h alive on Feb 1, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

2/1, 1923 (Address) 739 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 2-5-1923

20 UNDERTAKER Daniel Easton — ADDRESS 916 Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71940

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D71940

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Hillman ST., 9 WARD)

2-FULL NAME Nora F. Connelly

(a) RESIDENCE No. 1307 Hillman ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 26 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
		7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Edward J. Connelly

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary O'Connor

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Wm. Edward J. Connelly
(Address) 1307 Hillman St

15 Filed Feb 3 1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/1, 1923, to 2/2, 1923, that I last saw her alive on 2/2, 1923, and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? .....

(Signed) Dr Bernard Wells, M. D.

Feb 3, 1923 (Address) 914 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Feb 5 1923

20 UNDERTAKER: Henry Storck Son — ADDRESS: 130 E Eager St

3 - 1923

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71941

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mmergency Hospital St., 23 Ward) 179

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Thompson

(Residence in Baltimore: No. 1207 Pleasant alley St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. May (Month) 24 (Day) 1919 (Year)

7-AGE. 3 yrs. 8 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Born
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER, Chas Thompson

11-BIRTHPLACE OF FATHER, (State or Country). B. C.

12-MAIDEN NAME OF MOTHER, Emis Eppler

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E. Thompson

(Address) 1207 Pleasant alley

15- Feb 3 1923

Robert F. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 2 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, au- topsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Severe burns on entire body a few hrs.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Playing with matches set bed clothing afire

(Duration) yrs. mos. ds.

(Signed) W. R. Yarnall M. D. (Coroner.)

Feb 3 1923 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL, Feb 5 1923

20-UNDERTAKER, James Lig[illegible] Son ADDRESS 1000 E. Pleas on

3 1923

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Fanny Preston

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71942

CERTIFICATE OF DEATH.

129 D71942

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mrs Castles Sanatarium

CITY OF BALTIMORE: (No. Belgrade Ave New York Ave St. 13 WARD)

2-FULL NAME Fanny Preston

(a) RESIDENCE NO. 928 University Parkway WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 85				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER Dr Jacob Preston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER L Parman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant: Mrs. Preston
(Address) 928 University Parkway

15 Filed ROBERT F. HARTSOCK, Registrar
3-1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-2 19-23

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1923, to Jan 29, 1923, that I last saw her alive on Jan 29, 1923, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

(Paralysis R. Side
Arteriosclerosis.

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Intestinal Nephritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Haas M. D.

2-2 1923 (Address) 5600 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bellemount Cem — DATE OF BURIAL: Feb 3 1923

20 UNDERTAKER: Henry H Jenkins & Son Co — ADDRESS: Orchard & Mt Colle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

D71943

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

124

D71943

1-PLACE OF DEATH

Registered No. C

CITY OF BALTIMORE (No. 2101 Druid Hill Ave St.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Estelle A Lockerman

(Residence in Baltimore: No. 2101 Druid Hill Ave. 45 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: ~~Male~~ Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Unknown (Month) (Day), 1863 (Year)

7-AGE: 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): Principal

9-BIRTHPLACE (State or country): Newton Caroline Co Md

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs E Lockerman

(Address) 2101 Druid Hill Ave

15

Filed Robert F Carman, for

REGISTRAR

Burial Permit Clerk

3-1923

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 1 (Month) 31 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1922 to Jan 31 1923 that I saw h[illegible]ive on Jan 31, 1923 and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis with Arteriosclerosis

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) Bronchopneumonia

(Duration) 8 yrs. mos. ds.

(Signed) I Statham M. D.

2-2, 1923 (Address) 1202 Hall Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

FEB 3 1923

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn

DATE OF BURIAL: 2[illegible]61, 1923

20-UNDERTAKER: Samuel J Kemp

ADDRESS 575 N Bond St

Spec.—1-10-21—M&T—1500 Bks.

D71944

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D71944

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME Girl Hall

(a) RESIDENCE NO. 1148 Carrollton Ave, City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 23-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) Maryland

PARENTS

10 NAME OF FATHER Earl Hall

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Diggs

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Maryland

14 Informant ..... (Address) Records.

15 Robert P. Harrison, Registrar

Burial Permit Issued

2-3-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 26, 1923, to Jan. 28, 1923

that I last saw her alive on January 26, 1923,

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) ..... H. H. Weech ..... M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner of Health. Per. Wm. B. WOODALL.

ADDRESS FEB 3-1923

WHITE FEMALE, WHITE CHILD OR NEGRO—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D71945

CERTIFICATE OF DEATH

16 V D71945

REGISTERED No. C 8

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1731 E. Hoffman St.; 8 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Helen Ay

(Residence in Baltimore: No. 1731 E Hoffman St.; yrs. mos. ds.)

B-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: January 27, 1923 (Month) (Day) (Year)

7 AGE: yrs. mos. 5 ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Max Ay

11 BIRTHPLACE OF FATHER (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Lucy Ay

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Max Ay

(Address) 1731 E Hoffman

15 Robert P. Harrison,
Burial Permit Clerk
REGISTRAR

2-3-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: February 1, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27, 1923, to Feb. 1, 1923, that I saw her alive on Feb 1, 1923, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) yrs. mos. 5 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed), Chas. H. Stevens M. D.

Feb 2, 1923 (Address) 2878 Hanford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Carmel Cemetery | DATE OF BURIAL: Feby 3, 1923

20-UNDERTAKER: John J. Corcoran & Son | ADDRESS: 901 Hollins St

Spec.—1-10-21—M&T—1500 Bks.

D71946

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71946

CERTIFICATE OF DEATH.

X 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 Edmondson Ave St.; 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Kirby.

(a) RESIDENCE No. 1323 Edmondson Ave St., WARD Owenstown Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Edw Kirby

6 DATE OF BIRTH (month, day, and year) May 15 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Chas Edw Cockey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary A Legg.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Edna A. Rhodes

(Address) Owensstown Md.

15 FEB 3 1923 Robert P. Harrison Registrar

Municipal Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 31 1923 to Feb 3 1923.

that I last saw h alive on Feb 3 1923,

and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical signs

(Signed) [illegible] M. D.

2/3. 1923 (Address) 1405 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Owensstown Md.

DATE OF BURIAL 2-3 1923

20 UNDERTAKER E & B Hyde

ADDRESS 115 E Mad St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 3

Spec.—1-10-21—M&T—1500 Bks.

D71947

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D71947

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 N. Calvert ST., 11 WARD)

2-FULL NAME William J. Daugherty

(a) RESIDENCE NO. 926 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca Daugerty

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 73; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Wm. Daugherty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Priscilla Daugherty (Address) 926 N. Calvert St.

15 Filed 1923, 19 Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1922, to Feb. 2, 1923,

that I last saw him alive on Feb 2, 1923,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis asthma

Myocarditis

Chronic nephritis

Long (duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Frank J. Smith, M. D.

Feb. 3, 1923 (Address) 917 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Freedmans Ward

DATE OF BURIAL: 2d 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 50 N. Howard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3 - 1923

Spec.—1-10-21—M&T—1500 Bks.

3701 Carlton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71948

CERTIFICATE OF DEATH.

129

D71948

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3528 Roland ST., 13 WARD)

2-FULL NAME Aleen J. Eccard

(a) RESIDENCE NO. 3528 Roland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amanda A. Eccard

6 DATE OF BIRTH (month, day, and year): March 31

7 AGE — Years: 72 — Months: ..... — Days: ..... — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 016

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Frederick Co

PARENTS

10 NAME OF FATHER: Frederick Eccard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co

12 MAIDEN NAME OF MOTHER: Ebi Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co

14 Informant: Amanda Eccard (Address) 3528 Roland

15 Filed: Robert P. Harrison, Registrar

Burial Permit Clerk.

3 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-1 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-11 1923 to 2-1 1923

that I last saw h~~e~~ alive on 2-1 1923

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Softening

Pr. Intestinal infection

(duration) ..... yrs. ..... mos 20 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Typhoid negative

(Signed) C F Timberlake M. D.

2-2, 1923 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Frederick — DATE OF BURIAL: 2/4 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 532 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71949

D71949

CERTIFICATE OF DEATH.

4/1-00

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 N. Wallas ST., 6 WARD)

2-FULL NAME William Morris

(a) RESIDENCE NO. 124 N. Wallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, ~~Married~~, ~~Widowed~~, or Divorced, ~~(write the word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknow

7 AGE — Years: 27 — Months: — — Days: — — If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va,

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va,

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va,

14 Informant: Clara Young

(Address) 124 N. Wallas st

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2—2—1923

17

I HEREBY CERTIFY, That I attended deceased from 1-30-, 1923, to 2-2-, 1923.

that I last saw h— alive on 2-1-, 1923

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) about yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. P. Harrison, M. D.

2-2-1923 (Address) 614 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Usbury Cem — DATE OF BURIAL: 2/5/1923

20 UNDERTAKER: Jas. M. Skinner — ADDRESS: 1620 A. Madison st

B 3-1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D71950 HEALTH DEPARTMENT—CITY OF BALTIMORE D71950

CERTIFICATE OF DEATH.

159-002

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Evelyn Esther Ricketts.

(Residence in Baltimore: No. 106 S. Collington Ave. St.; 4 yrs. --- 4 mos. --- 15 ds.)

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female.	White.	Single.

6-DATE OF BIRTH. September 17, 1918.
(Month) (Day) (Year)

7-AGE. 4 yrs. 4 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Harry E. Ricketts.

11-BIRTHPLACE OF FATHER, (State or Country) Deales Island Md.

12-MAIDEN NAME OF MOTHER. Ruth E. McDaniel.

13-BIRTHPLACE OF MOTHER, (State or Country) Deales Island Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry E. Ricketts. (father).
(Address) 106 Collington Ave.

15- FEB 3 1923 Robert E. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 1st. 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Acute dilatation of the heart.
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt M.D.
(Coroner.)

Feb. 2nd 1923. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? .....
19b S. Collington Ave.
Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cremation [illegible]	Feb 3rd 1923

20-UNDERTAKER.	ADDRESS
[illegible]	[illegible]

HEALTH DEPARTMENT--CITY OF BALTIMORE

D71951 PLACE OF DEATH

CERTIFICATE OF DEATH

101 ~ D71951 REGISTERED No. C

CITY OF BALTIMORE (No. 2532 Pennsylvania Ave WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Helen E. Martin

(Residence in Baltimore: No. 2532 Pennsylvania Ave St.; yrs. 8 mos. 21 ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 SINGLE, ~~MARRIED~~ ~~WIDOWED~~ OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: May (Month) 11 (Day), 1922 (Year)

7 AGE: yrs. 8 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: 0
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9 BIRTHPLACE (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Ralph A Martin

11 BIRTHPLACE OF FATHER (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Florence L. Gidinger

13 BIRTHPLACE OF MOTHER (State or country): Carroll Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph G. Martin
(Address) 2532 Pennsylvania

15 [illegible]
Filed , 191
Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 1 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31, 1923 to Feb 1 1923.
that I saw her alive on Feb 1 1923
and that death occurred, on the date stated above, at 8 45 p.m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 1 ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) R A M D
2/2, 1923. (Address) 2733 W Fairmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Feb 3, 1923

20 UNDERTAKER: Robt J Turner Sons — ADDRESS: 1412 N Broadway

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71952

CERTIFICATE OF DEATH.

D71952

1-PLACE OF DEATH

REGISTERED No. C 161-00

CITY OF BALTIMORE: (No. 523 Rossiter Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Not named Baby Cantrille

(Residence in Baltimore: No. 523 Rossiter Ave St.; ..... yrs., ... mos. 8 hours ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Feb 1, 1923 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
....yrs....mos....da.	8 hrs. or....mtn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, Thos Carson Cantrille

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Storey

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T C Cantrille

(Address) 523 Rossiter Ave

15- Robert F. Harrison

Filed ....., 191.... Burial Permit Clerk.

FEB 3 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 1, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1, 2 "P.M." 1923, to Feb 1. 10 P.M. 1923, that I saw h[illegible] alive on Feb 1 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Dystocia

..... (Duration) .....yrs.....mos.....da.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs.....mos.....da.

(Signed) Geo. H. Hocking M. D.

2/2, 1923 (Address) 5835 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St John Cemetery	Feb 3, 1923
20-UNDERTAKER George J Smith	ADDRESS 1532 Gilmor St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D71953

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D71953

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 22 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Lee

(a) RESIDENCE NO. Salvation Army Home ST., SHARP St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Lee

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Bush

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Municipal Hospital Records.
(Address)

15 Filed , 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 19 23

17

I HEREBY CERTIFY, That I attended deceased from January 24, 19 23 to February 1, 19 23, that I last saw him alive on January 31, 19 23, and that death occurred, on the date stated above, at 7:00 A. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Alfred Neal, M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Feb 3 1923

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71954

CERTIFICATE OF DEATH.

Hearn, 3901 Garrison Ave

9 12

D71954

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1749 Lamont ST., 9 WARD)

2-FULL NAME Rose Mason

(a) RESIDENCE No. 1749 Lamont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Robert Mason

6 DATE OF BIRTH (month, day, and year): Feb 2 1844

7 AGE: Years 78 | Months 11 | Days 29 | If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Hugh McKenna

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mathew McKenna

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Catherine J. Mullaley (Address) 1749 Lamont St

15 Robert F. Mattes, Registrar

FEB 3 - 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1923, to Feb 1, 1923, that I last saw h[illegible] alive on Jan 31, 1923 and that death occurred, on the date stated above, at 145 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Kidney Disease

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Acc Cgl

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Hearn, M. D.

2/2, 1923 (Address) 3901 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Hayward

DATE OF BURIAL: 2/5 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 [illegible] North

B.—WRITE PLAINLY with pen and ink. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Emma

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71955

CERTIFICATE OF DEATH.

D71955

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 2 Devonshire Drive ST.: 7 WARD)

2-FULL NAME Ema. Place

(a) RESIDENCE. NO. 2. Devonshire Drive ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank H Place

6 DATE OF BIRTH (month, day, and year) Aug 25 80

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. J.

PARENTS

10 NAME OF FATHER Philip Hettrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Klinck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant F H Wilcox (Address) 2 Devonshire Drive

15 Filed FEB 3 - 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb. 2, 1923, that I last saw her alive on Feb 2nd, 1923, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H H Goodnough, M. D.

, 19 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Feb 5 1923
20 UNDERTAKER W M Rowson	ADDRESS 2238 N Paca

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71956 D71956

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 E. 20 ST.: 17 WARD)

2-FULL NAME Marg. Eliz. Watson

(a) RESIDENCE. No. 210 E. 20 ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Airey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Jamima Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Miss Maud Watson

(Address) 210 E. 20th

15 Filed FEB 3 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-11-17, 19..., to 2-1, 1923, that I last saw h.er alive on 2-1, 1923, and that death occurred, on the date stated above, at 12.10 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical only

(Signed) O'Kieffe J. Fowler, M. D.

2.3.23 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Feb 19

20 UNDERTAKER W. Cook B.J. ADDRESS 502 E. Hunt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D71957

CERTIFICATE OF DEATH

90 D71957

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 861 Harlem Avenue St. ..... WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Murphy

(Residence in Baltimore: No. 861 Harlem Ave. St. 10 yrs. 8 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: May (Month) 10 (Day), 1835 (Year)

7-AGE: 87 yrs. 8 mos. 23 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Robert Mills

11-BIRTHPLACE OF FATHER (State or country): Ireland

12-MAIDEN NAME OF MOTHER: Elizabeth Newton

13-BIRTHPLACE OF MOTHER (State or country): England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret H Hart

(Address) 861 Harlem Ave.

15-

Feb 3 1923

Robert P. Harrison,
REGISTRAR

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: February (Month) 2 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1923, to, February 2, 1923, that I saw h[illegible] alive on February 1, 1923, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Organic heart disease
(Mitral Stenosis)

(Duration) ..... yrs. 6 mos. 25 ds

Contributory (SECONDARY) Bronchopneumonia, Influenza

(Duration) ..... yrs. 6 mos. 25 ds.

(Signed) A M Stevenson M.D.

2/3, 1923 (Address) 2733 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt. Olivet

DATE OF BURIAL: Feby 5, 1923

20-UNDERTAKER: John O. Mitchell

ADDRESS: 1201 W. Fayette St.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D71958

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D71958

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 14 WARD)

2-FULL NAME Edward Short.

(a) RESIDENCE NO. 2109 Druid Hill Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie Short

6 DATE OF BIRTH (month, day, and year): Sept 3 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Orderly

(b) General nature of industry, business, or establishment in which employed (or employer): Provident Hospital

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Florence Mahoney

(Address) 2109 Druid Hill Ave

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 1st 1923

17. I HEREBY CERTIFY, That I attended deceased from Jan 28th, 1923, to Feb 1st 1923.

that I last saw him alive on Feb 1st 1923

and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Cerebral Apoplexy

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry F Brown, M. D.

(Address) 1501 Presstman st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Saint Peters Cem — DATE OF BURIAL: Feb 5 1923

20 UNDERTAKER: Mrs Robert A Elliott — ADDRESS: 1725 Mechland Ave

8-1923

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

160774 Dept. File 11

D71959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71959

100-00

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 76 WARD)

2-FULL NAME Howard H Howell

(a) RESIDENCE No. 3721 E. Pratt St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Hospl mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 24 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Martin S. Howell

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Ruth McAllister

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Records.
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed FEB 3 - 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923, to Feb 2, 1923,

that I last saw him alive on Feb 2, 1923,

and that death occurred, on the date stated above, at 11 PM m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) none

none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore City

Did an operation precede death? Date of no

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. A. Reed, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL Feb 5 1923

20 UNDERTAKER Ehrenwerth Son — ADDRESS Chestnut

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D71960

HEALTH DEPARTMENT—CITY OF BALTIMORE

901-001 D71960

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mavin & Hollins Sts. St. Masonville. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M. Racines.

(Residence in Baltimore: No. Mavin & Hollins Sts. Masonville. St.; yrs. 21 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White.	Widow.

6-DATE OF BIRTH. Do not know. 1 (Month) (Day) (Year)

7-AGE. 80 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Carroll Co. Md.

PARENTS.

10-NAME OF FATHER. William Crabb.

11-BIRTHPLACE OF FATHER, (State or Country). Scotland.

12-MAIDEN NAME OF MOTHER. Sallie Godfrey.

13-BIRTHPLACE OF MOTHER, (State or Country). Howard Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Racines. (daughter).

(Address) Mavin & Hollins Sts. Masonville.

15- Filed 1923 192

Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 1st. 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Eichhardt M. D. (Coroner)

Feb. 2nd, 1923. (Address) 10 W. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Marys Hampden DATE OF BURIAL. Feb 3 1923

20-UNDERTAKER Chenoweth Son ADDRESS Chestnut Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

3

(Steinbakers)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71961 — CERTIFICATE OF DEATH. — 101-00 — D71961

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be very particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 407 W. 26 ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William Steinbaker

(Residence in Baltimore: No. 407 W - 26 st St. 2 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX. M

4 COLOR OR RACE W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) married

6 DATE OF BIRTH unknown (Month) (Day) 1853 (Year)

7 AGE. 69 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

PARENTS.

9 BIRTHPLACE. (State or Country) Unknown

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or Country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Steinbaker

(Address) 407 W 26 st

15 Filed FEB 3 1923, 191 Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 2 (Month) (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

1a Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Address) 913 Robb

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, OR REMOVAL. Poplar Balto DATE OF BURIAL. Feb 4, 1923

20 UNDERTAKER Spenawetz & Son ADDRESS Spenawetz

Spec.—1-10-21—M&T—1500 Bks.

71962

HEALTH DEPARTMENT—CITY OF BALTIMORE

71962

D71962

CERTIFICATE OF DEATH.

31

D71962

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Pennsylvania ave ST., 14 WARD)

2-FULL NAME George F. Sommers Jr

(a) RESIDENCE NO. 1906 Pennsylvania ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 2 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 2 - 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	2	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Government

(c) Name of employer Service Balto

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo Sommers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Hehman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Geo Sommers (Address) 1906 Penna ave

15 Filed FEB 4 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1923, to Feb 1, 1923, that I last saw him alive on Jan 31, 1923, and that death occurred, on the date stated above, at 10 45 A m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab

(Signed) Paul Brown, M. D.

2/1, 1923 (Address) 1852 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 2/5/1923

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71963 D71963 D71963

CERTIFICATE OF DEATH.

160

REGISTERED NO. D71963

1-PLACE OF DEATH St Vincents Infant Asy

CITY OF BALTIMORE: (No. 1401 - division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Killerman

(a) RESIDENCE NO. 140 / Division St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9" 1922

7 AGE: Years | Months: 4 | Days: 28 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Vincents Infant Asy. Balto. Md (State or country)

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER Marie Killerman

13 BIRTHPLACE OF MOTHER (city or town) Phila (State or country) Pa.

14 Informant St Vincents Infant Asy (Address) Balto. Md

15 Filed FEB 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk:

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 9, 1922, to Feb 2, 1923, that I last saw him alive on Feb 1, 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Congenital debility -

(duration) from birth yrs. mos ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. L. Goldsborough Jr. M. D.

, 19 (Address) 2735 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudenslager

DATE OF BURIAL Feb 5 1923

20 UNDERTAKER Martin Frankenberg

ADDRESS 1637 W. North

CAUSE OF DEATH—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cathell Catons

71964 HEALTH DEPARTMENT—CITY OF BALTIMORE 71964

D71964 CERTIFICATE OF DEATH. X187-607 D71964

Registered No. C.....

1-PLACE OF DEATH Providence and St Joseph Hospitals

City of BALTIMORE: (No. St. Joseph Hospital St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Cathell Catons

(Residence in Baltimore: No. Jappa Md St.; yrs. (10 mos.) ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Feb (Month) 2 (Day) 1899 (Year)

7-AGE. 24 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Laborer (b) General nature of industry, business, or establishment in which employed (or employer). Saw Mill

9-BIRTHPLACE, (State or Country). Culpepper Co Va

PARENTS.

10-NAME OF FATHER. William Catons

11-BIRTHPLACE OF FATHER. (State or Country). Virginia

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Shepard

(Address) Jappa Md

15- Filed FEB 4 - 1923 192.

ROBERT R. KRAMER

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 2 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage — By tearing his rt leg Cut off above knee Abdomen opened by tearing or Circumcision (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Drowning (Duration) yrs. mos. ds.

(Signed) J S Patterson M. D. (Coroner.)

2-3 1923 (Address) 508 E Monument

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Culpepper Co. Virginia	Feb. 4th 1923
20-UNDERTAKER.	ADDRESS
Frank Lescombe Sons	Fallston Md

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

71965

D71965

HEALTH DEPARTMENT—CITY OF BALTIMORE

71965

168

D71965

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4505 Laurella Av St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Walch

(Residence in Baltimore: No. 4505 Laurella Av St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH. May (Month) 26 (Day) 1844 (Year)

7-AGE. 87 yrs. 8 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer)..... Baker

9-BIRTHPLACE, (State or Country). Germany

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. J. Engel Son

(Address) 4505 Laurella Av

Filed FEB 4 - 1923 192.....

ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 2 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide - Strangulation by hanging - over bed post in bed room

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Collins M. D. (Coroner.)

2-3 1923 (Address) 408 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL. Feb 5th 1923

20-UNDERTAKER. Fred Lassahn Sons

ADDRESS Fullerton Md

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Rank 1370 St Charles 160

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71966

CERTIFICATE OF DEATH.

D71966

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (a) No. 804 St. Peters ST., 21 WARD)

2-FULL NAME Mary L. Davis

(a) RESIDENCE NO. 804 St Peters ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15/22

7 AGE Years Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry L. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Edith Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A Co Md

14 Informant Edith Davis
(Address) 804 St Peter St

15 FEB 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28 1923 to July 1 1923

that I last saw h alive on July 1 1923

and that death occurred, on the date stated above, at 715 P m.

The CAUSE OF DEATH* was as follows:

Mal-Nutrition

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Diarrhoea

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? none

What test confirmed diagnosis?

(Signed) H Krauter, M. D.

, 19 (Address) 1340 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Marleys Burial Ground DATE OF BURIAL 2/4 1923

UNDERTAKER William Cook ADDRESS 502 E Mont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71967

CERTIFICATE OF DEATH.

Walbrook 129 D71967

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3727 North Road ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elizabeth Mentzel

(a) RESIDENCE. No. 3727 North Road ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 21 1831

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
91	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Conrad Haas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: F. E. Deuhard

(Address): 3727 North Road

15 DEC 4 - 1923 ROBERT R. KRAUSER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1923, to Feb 3, 1923, that I last saw her alive on Feb 3, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

arteriosclerosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary): Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clin

(Signed) Wm. E. Stifler, M. D.

2/3, 1923 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: Feb. 5 1923

20 UNDERTAKER: Wm. Cook

ADDRESS: 502 S. Gay

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71968

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124

D71968

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507½ Covington ST., 7 WARD)

2-FULL NAME Fannie B. Sutch.

(a) RESIDENCE No. 1507½ Covington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: John Sutch.

6 DATE OF BIRTH (month, day, and year): Dec 14, 1876

7 AGE: Years 46 Months 1 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

039

9 BIRTHPLACE (city or town) (State or country): Howard Co Md

PARENTS

10 NAME OF FATHER: James H. Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co Md.

12 MAIDEN NAME OF MOTHER: Tibothy Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co Md

14 Informant: John Sutch

(Address) 1507½ Covington St

15 FEB 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 1. 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1923, to Feb 1, 1923, that I last saw her alive on Feb 1, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Parenchymatous Nephritis (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Sidney H. Street, M. D.

2/2 1923 (Address) 410 S. N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 2/5 1923

20 UNDERTAKER: Margaret J. Flynn

ADDRESS: 422 Light St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71969 D71969

CERTIFICATE OF DEATH.

178

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 111 Clayton Court. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth T. M. Phillips.

(Residence in Baltimore: No. 111 Clayton Court. St.; 12 --- yrs., 7 --- mos., 4. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	White.	Single

6-DATE OF BIRTH. June 28, 1910.
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
12 yrs. 7 mos. 4. ds.	....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. William P. Phillips.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Elizabeth Stumpf.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William P. Phillips. (father.)
(Address) 111 Clayton Court

15. FEB 4 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. February 1st, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental suffocation by smoke.
Trapped in a burning house.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D. (Coroner)

Feb. 2nd, 1923. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. ....yrs. ....mos. ....ds. In the State. ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cedar Hill DATE OF BURIAL. 2/5/ 1923

20-UNDERTAKER. Margaret A. Flynn ADDRESS 1427 Eutaw St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71970 ✓ 178 D71970

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 111 Clayton Court. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian H.Phillips.

(Residence in Baltimore: No. 111 Clayton Court. St.; 9 yrs., 8 mos., 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female.	White.	Single.

6-DATE OF BIRTH. May 27, 1913.
(Month) (Day) (Year)

7-AGE. 9 yrs. 8 mos. 5 ds. — If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. William P.Phillips.

11-BIRTHPLACE OF FATHER. (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Elizabeth Stumpf.

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William P.Phillips.(father).

(Address) 111 Clayton Court.

15-FEB 4 - 1923 ROBERT R. KRAUTER,
Filed ..... 192.... Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 1st. 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental suffication by smoke.
Trapped in a burning house.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY, (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Otto E. Reinhardt M. D.
(Coroner.)

Feb. 2nd, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cemetery	Feb. 5 1923

20-UNDERTAKER.	ADDRESS.
Margaret E. Flynn	142 Light St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D71971 HEALTH DEPARTMENT—CITY OF BALTIMORE D71971

CERTIFICATE OF DEATH. 2478

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 111 Clayton Court. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth M. Phillips.

(Residence in Baltimore: No. 111 Clayton Court. St.; yrs. 46 -- mos. 7 --- ds. 22.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	White.	Married.

6-DATE OF BIRTH, June 10, 1876. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
46 yrs. 7 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(h) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank Stumpf.

11-BIRTHPLACE OF FATHER, (State or Country). Germany.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William P. Phillips. (husband).

(Address) 111 Clayton Court.

15- Filed FEB 4 - 1923 (1923) ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 1st. 1923. 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental suffocation by smoke.
Trapped in a burning house.

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)..... (Duration)..... yrs..... mos..... ds.

(Signed) Otto M. Eisenhardt M. D. (Coroner)

Feb, 2nd, 1923. (Address) 1014 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cemetery	Feb. 5 1923
20-UNDERTAKER. Margaret L. Flynn	ADDRESS 1422 Light St.

Spec. 1921 M&T 1500 Bks.

D71972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71972

CERTIFICATE OF DEATH.

74-001

N. B.—WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2910 E. Monument ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Stone

(a) RESIDENCE No. 2910 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William L. Stone

6 DATE OF BIRTH (month, day, and year) July 31st 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	6	1	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George Riley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Meeks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Miss Katherine Stone
(Address) 2910 E. Monument St

15 Filed FEB 4-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1923

17 I HEREBY CERTIFY, ~~That~~ I attended deceased from Jan 31, 1923 to Feb 2, 1923

that I last saw h alive on Feb 1, 1923

and that death occurred, on the date stated above, at 3-15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. L. Campbell M. D.

Feb 3, 1923 (Address) 1649 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Feb 6 1923

20 UNDERTAKER E. Schumacher Son

ADDRESS 1649 Hanover St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D71973

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71973

CERTIFICATE OF DEATH.

10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 340 St. Helena ave St. 26 WARD)

2-FULL NAME Herbert Ashley Myers.

(a) RESIDENCE. No. 340 St Helena ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 6 - 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Melvin A. Myers

11 BIRTHPLACE OF FATHER (city or town) East Berlin, Pa.
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Anna Scheiner

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Melvin A Myers
(Address) 340 St Helena Ave, St Helena

15 FEB 4 - 1923 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from January 31, 1923, to Feb 3, 1923,
that I last saw him alive on Feb 3, 1923,
and that death occurred, on the date stated above, at 3-30 P. m.

The CAUSE OF DEATH* was as follows:

Diptheritic
Tonsillar & Pharyngeal

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological

(Signed) A.W. Reier, M. D.

2/3, 1923 (Address) 1 Kirkship Rd Dundalk Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Feb 4 1923

20 UNDERTAKER H E Hughes ADDRESS 424 N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71974

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90

D71974

Registered No. C.....

City of BALTIMORE: (No. 1923 W. Mosher St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Elizabeth Rinn

(Residence in Baltimore: No. 1923 W. Mosher St.; yrs. 45 mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female | 4-COLOR OR RACE, white | 5-Single, Married, Widowed, or Divorced, (Write the word.) widow

6-DATE OF BIRTH, Nov. 19 1839
(Month) (Day) (Year)

7-AGE, 83 yrs. 2 mos. 14 ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS:

10-NAME OF FATHER, Joseph Fridag

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Leinbach

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Henry Rinn

(Address)..... Hazlethorst, Md.

15-Filed FEB 4 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 2, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Feb 3 1923 (Address) 2502 E Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem | DATE OF BURIAL, 2/5/23

20-UNDERTAKER, H. Jordan & Son | ADDRESS 2175 Pres

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71975

CERTIFICATE OF DEATH.

129 D71975

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2100 E Balto St ST., 1 WARD)

2-FULL NAME Rosa Weber

(a) RESIDENCE NO. 2100 E Balto St ST., ... WARD .....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 38 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 38 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Aaron Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant A. Weber

(Address) 1816 Linden Ave

FEB 4 - 1923 Filed ..... 19 .....

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/3 1923

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1922, to Feb 2, 1923, that I last saw h alive on Feb 2, 1923, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

a. Hypertension

(duration) 1 yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary)

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of ... - - -

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Samuel Lutherman M. D.

, 19 (Address) 1810 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave — DATE OF BURIAL 2/4 1923

20 UNDERTAKER S. Levinson & Bro — ADDRESS 1127 E Balto St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D71976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D71976

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 76 WARD)

2-FULL NAME Alexander Friedman

(a) RESIDENCE No. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
35	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 09

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Sam Friedman

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Municipal Hospital Records.
(Address)

15 Filed FEB 4 - 1923, 19 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 19 23

17 I HEREBY CERTIFY, That I attended deceased from January 31, 19 23, to February 3, 19 23.

that I last saw him alive on February 2, 19 23.

and that death occurred, on the date stated above, at 6:45 A.M p.m.

The CAUSE OF DEATH* was as follows:

Acute alcoholism (Corr)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde M. Mell, M. D.

2-3-, 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rock Road

DATE OF BURIAL 2/4 19 23

20 UNDERTAKER Jack Lewis

ADDRESS 1423 E Balto St

Jewish

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71977

CERTIFICATE OF DEATH.

101-001 D71977

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 S. Smallwood St. ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Friedman

(a) RESIDENCE. No. 506 S. Smallwood St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia Friedman

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ladies Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Sam Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1439 E. Baltimore St.

15 Filed FEB 4 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1923, to Feb 2, 1923, that I last saw h[er] alive on Feb 2, 1923, and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Toxaemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Was Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kahn M. D.

Feb. 4, 1923 (Address) 2227 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mark Wood — DATE OF BURIAL 2/4 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Baltimore St

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mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Scher

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71978

CERTIFICATE OF DEATH.

90 D71978

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 124 N Exeter ~~Street~~ ST., 5 WARD)

2-FULL NAME Rose Leah Scher

(a) RESIDENCE NO. 124 N Exeter St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leah Scher

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1439 E Baltimore St

15 Filed FEB 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/4 1923

17 I HEREBY CERTIFY, That I attended deceased from January 31, 1923, to Feb 3, 1923, that I last saw her alive on Febry 3rd, 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) acute dilatation of heart

(duration) ..... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Samuel Silverstein, M. D.

, 19 (Address) 22 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 2/4 1923

20 UNDERTAKER Jack Levis 1439 E Baltimore St — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71979

D71979

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 Mosher ST., 14 WARD)

2-FULL NAME Nannie Pennington

(a) RESIDENCE NO. 629 mosher ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~#8~~

6 DATE OF BIRTH (month, day, and year) Unknown 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fred Co Md

PARENTS

10 NAME OF FATHER Cadwallader Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Nannie Pennington
(Address) 629 Mosher St

15 FEB 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1922 to Feb. 1, 1923

that I last saw h[illegible] alive on Feb. 1, 1923

and that death occurred, on the date stated above, at 1:25 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward J. Woolley, M. D.

2/8, 1923 (Address) 1280 E. Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 2/4 1923

20 UNDERTAKER Saml J Hemsley

ADDRESS 578 N Bond

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71980

CERTIFICATE OF DEATH.

129 D71980

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

2-FULL NAME Henrietta Scott

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1852 ?

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
70 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Municipal Hospital Records.

15 Filed FEB 4 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31 1923

17 I HEREBY CERTIFY, That I attended deceased from January 31, 1923, to January 31 1923, that I last saw her alive on January 31, 1923, and that death occurred, on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde M. Hirst M. D.

(Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Moriah Lancaster Co Pa

DATE OF BURIAL 2/4 1923

20 UNDERTAKER Samuel T Hemerley

ADDRESS 518 N Bridle

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71981

CERTIFICATE OF DEATH.

11-001 D71981

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 N. Central ave. ST., 10 WARD)

2-FULL NAME Mary Griesbaum

(a) RESIDENCE. NO. 1002 N. Central ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? Inf. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE: Years 57 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Pottsville Pa.

PARENTS

10 NAME OF FATHER: Mathias Griesbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country): German

12 MAIDEN NAME OF MOTHER: Amelia Knecht

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Catherine Hughes

(Address) 1002 N Central Ave

15 Date received FEB 4 - 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2. 2. 1923.

I HEREBY CERTIFY, That I attended deceased from January 30 1923 to Febry 2 1923.

that I last saw h alive on Febry 2 1923.

and that death occurred, on the date stated above, at 4 45 p.m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jules Hall. Mey M. D.

2/3, 1923 (Address) 1031 N. Carrollcae

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pottsville. Pa. DATE OF BURIAL: Febry 5 1923

20 UNDERTAKER: Henry Horch Son ADDRESS: 1301 E Eleventh

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71982

CERTIFICATE OF DEATH.

74-001 D71982

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1612 Rutland ave ST., 8 WARD)

2-FULL NAME John. N. Key

(a) RESIDENCE No. 1612 Rutland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Margaret C Key

6 DATE OF BIRTH (month, day, and year) Most Known

7 AGE: Years 71 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Mariner 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phila. Pa.

PARENTS

10 NAME OF FATHER: Geo. H. Key

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Mary Gear

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Mrs Margaret C. Key

(Address) 1612 Rutland ave

15 FEB 4 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 2 1923

17

I HEREBY CERTIFY, That I attended deceased from June 27, 1923, to Feb 1, 1923,

that I last saw h— alive on Feb 1, 1923,

and that death occurred, on the date stated above, at 8 35 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H Carey, M. D.

, 19 (Address) 1603 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Friday 5 1923

20 UNDERTAKER: Kinney Torch Son — ADDRESS: 1301 E Eager

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71983 — CERTIFICATE OF DEATH. — X 31 — D71983

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 716 R. Stockton ST., 16 WARD)

2-FULL NAME Aaron Comadal Tunstell

(a) RESIDENCE NO. 716 Stockton ST., WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M — 4 COLOR OR RACE Col — 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1908

7 AGE — Years 15 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stoker

(b) General nature of industry, business, or establishment in which employed (or employer) Chauffeur

(c) Name of employer W L Waine Norfolk Va

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Lewis H Tunstell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Estes Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant L H Tunstell (Address) 716 R. Stockton

15 Filed FEB 4 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1923

17 I HEREBY CERTIFY, That I attended deceased on June 14, 1923 to Jan 19, 1923.

that I last saw h alive on Feb 1, 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward A Morgan M. D.

2/, 1923 (Address) 1322 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hopes Mt Essex Co Va — DATE OF BURIAL Feb 4 1923

20 UNDERTAKER Sam'l W Chase Sons — ADDRESS 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71984

CERTIFICATE OF DEATH.

129 D71984

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 W Biddle ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry L. Imele

(a) RESIDENCE. No. 112 W Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 2, 1858

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
64	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Policeman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

061

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Imele

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dorothea Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles Imele (Address) Park Ave & Biddle St

15 FEB 4 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1922 to Feb 2, 1923, that I last saw him alive on Feb 2, 1923, and that death occurred, on the date stated above, at 6 34 PM m.

The CAUSE OF DEATH was as follows:

Chronic Myocarditis

Chronic Hypertrophic Nephritis

(duration) 8 yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Elmer B Truman M. D.

FEB 3 1923 (Address) 412 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ DATE OF BURIAL

London Park FEB 5 1923

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D71985

CERTIFICATE OF DEATH.

101-001 D71985

1-PLACE OF DEATH 205 W Madison Street

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Catherine ST. 11 WARD)

2-FULL NAME Mrs ~~Katherine~~ R. Robinson

(a) RESIDENCE NO. 205 W. Madison ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert K. Robinson

6 DATE OF BIRTH (month, day, and year) Oct 1, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Caroline Co., Md

PARENTS

10 NAME OF FATHER Thos. Culbreth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Caroline Co Md.

12 MAIDEN NAME OF MOTHER Elmira ~~Culbreth~~ Oliver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Milford Delaware

14 Informant Katharine B. Robinson
(Address) 205 W. Madison St

15 Filed FEB 4 — 1923, 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. ?, 1920, to Feb 2, 1923,
that I last saw her alive on Feb 2 1923,
and that death occurred, on the date stated above, at 1:35 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History + physical examination

(Signed) Chas Cloyd Judd M. D.

, 19 (Address) 170 Madison Ave, Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington Del — DATE OF BURIAL Feb 5 1923

20 UNDERTAKER Henry W. Jenkins Sons — ADDRESS McCulloh & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

161 D71986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D71986

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

JOHNS HOPKINS HOSPITAL

2-FULL NAME Lillian Williams

(a) RESIDENCE No. 428 S. Fairmount St. City ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? yrs. 10 mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		0		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) .....
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Eric Williams

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va.

12 MAIDEN NAME OF MOTHER Lena Jones

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va.

14 Informant Records JOHNS HOPKINS HOSPITAL.
(Address)

15 FEB 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) Feb. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1923, to Feb. 1, 1923, that I last saw h[illegible] alive on Feb. 1, 1923, and that death occurred, on the date stated above, at 10 [illegible] (P) m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs. ..... mos 16 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Tuberculin

(Signed) H. H. Wood M.D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL Feb 4 1923

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71987

CERTIFICATE OF DEATH.

31

REGISTERED NO. C D71987

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 E Monument ST.; 7 WARD)

(If death occurred in a hospital or Institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Saverstw Floyde

(Residence in Baltimore: No. 1606 E. Monument St.; 13 yrs.. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept (Month) 20 (Day), 1904 (Year)

7-AGE, 18 yrs. 4 mos. 12 da. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Messenger
(b) General nature of industry, business, or establishment in which employed (or employer): Co

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Garland Floyde

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Maria Campbell

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maria Floyde (Mother)

(Address) 1606 E Monument

15- FEB 4 1923 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 2 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 14 1923, to Feb 2 1923, that I saw h[er] alive on Feb 1 1923, and that death occurred, on the date stated above, at 10P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

to my Knowledge

(Duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) R J Young M. D.

2 2, 1923 (Address) 1424 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn cemetery

DATE OF BURIAL, Feb 14, 1923

20-UNDERTAKER Edward Bryan

ADDRESS 631 Orleans St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D71988

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D71988

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 928 N Eutaw ST., 11 WARD)

2-FULL NAME Grace Viola Devann

(a) RESIDENCE NO. 928 N. Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mack Devann

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
25	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Y. M. C. A.

9 BIRTHPLACE (city or town) (State or country) Bath City

PARENTS

10 NAME OF FATHER Henry A. Shuster

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Annie Rose

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant (Address) Frederick Shuster 928 N Eutaw

15 Filed FEB 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to Feb 1, 1923, that I last saw h[illegible] alive on Jan 31, 1923, and that death occurred, on the date stated above, at 6:50 a m.

The CAUSE OF DEATH* was as follows:

Cyanosis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Abscess of Rectum

(duration) yrs. mos. 22 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? no Date of [illegible]

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) John H Tompsins M. D.

, 19 (Address) 1014 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Feb. 4 1923

20 UNDERTAKER Jno. H. Toadvine — ADDRESS 142 W. Hill St.

Spec.—1-10-21—M&T—1500 Bks.

D71989

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 75 = 002

D71989

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4422 Wrenwood (St.) (WARD)

2-FULL NAME Ureth Howard Lynch

(a) RESIDENCE NO. 4422 Wrenwood Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: widow of John Lynch

6 DATE OF BIRTH (month, day, and year): April 6 1834

7 AGE: 88 Years 9 Months 23 Days. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Warren Baltimore Co Md.

PARENTS

10 NAME OF FATHER: John Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Near Warren Balto Co Md

12 MAIDEN NAME OF MOTHER: Sarah Ann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Near Warren Balto Co Md

14 Informant: Great Neice Address: 4422 Wrenwood Ave

15 Filed FEB 4 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 31st 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 27, 1923, to Jany 31, 1923, that I last saw her alive on Jany 31, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Senile Paralysis

(duration) yrs. 2 mos 7 ds.

CONTRIBUTORY (Secondary): Chronic Laryngitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dallard R Smith, M. D.

, 19 (Address) 709 Arlington Ave Govans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Cemetery Balto Co

DATE OF BURIAL: 2/4 1923

20 UNDERTAKER: Wellington Cook

ADDRESS: 502 E Monument

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71990

CERTIFICATE OF DEATH.

100-001 D71990

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Byrd ST., 24 WARD)

2-FULL NAME Doris G. Miller

(a) RESIDENCE NO. 1716 Byrd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with unfading ink—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Dec 3 1921

7 AGE: Years 1 Months 2 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Robt C. Miller

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Addie E. Sperry

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Mr Robt C Miller (Address) 1716 Byrd St

15 Filed FEB 4 1923 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1923, to Feb 3, 1923, that I last saw h alive on Feb 2, 1923, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Primary) (duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell, M. D.

Feb 3, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem DATE OF BURIAL 2/5 1923

20 UNDERTAKER: J. F. McCully ADDRESS 1304 E. Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D71991

REGISTERED No. D71991

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3721 Roland Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doctor George F. Shower

(a) RESIDENCE. NO. 3721 Roland Ave West 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Leslie Shower

6 DATE OF BIRTH (month, day, and year): Aug. 20-1841

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
81	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Manchester Maryland

PARENTS

10 NAME OF FATHER: Judge Adam Shower

11 BIRTHPLACE OF FATHER (city or town) (State or country): Manchester Maryland

12 MAIDEN NAME OF MOTHER: Mary A. Gerger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Manchester Maryland

14 Informant (Address): Mrs. L. L. Shower 3721 Roland Ave

15 FEB 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 2nd 192[illegible]

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29th, 1923, to Feb 2nd, 1923, that I last saw h[illegible] alive on Feb 1st, 1923, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 6 d[illegible]

CONTRIBUTORY (Secondary)

(duration) yrs. mos. d[illegible]

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W G Jones, M. D.

2/4, 1923 (Address) 720 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: Feb. 5 192[illegible]

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 3631 Falls Rd

Spec.—1-10-21—M&T—1500 Bks.

D71992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D71992

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 N Stricker ST., 16 WARD)

2-FULL NAME Kate E. Haupt.

(a) RESIDENCE NO. 1024 N Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H Haupt

6 DATE OF BIRTH (month, day, and year) May 27 1847

7 AGE Years 75 Months 5 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm H Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah May

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm H Haupt (Address) 1024 N Stricker St

15 Filed FEB 4 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1923, to Feb. 1 1923, that I last saw her alive on Feb. 1 1923, and that death occurred, on the date stated above, at 12.15 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Arthritis

(duration) 3 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Marshall G. Smith, M. D.

2-2. 1923 (Address) 118 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville, Md

DATE OF BURIAL 2/6/23

20 UNDERTAKER Joyce & Talley Funeral Parlors

ADDRESS

D71993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71993 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 427 W. Hoyt St., 5 Ward)

2-FULL NAME Lillian Summers

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 427 W. Hoyt St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	

6-DATE OF BIRTH,

.....(Month) ....., 1..... (Day) (Year)

7-AGE, 39 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- FEB 4 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 2, 1923.
.....(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or Inquiry.)
thereon and from the evidence obtained by said inquest, autopsy or Inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed).....M. D.
(Coroner.)
#4
.....192....(Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart — DATE OF BURIAL, Feb 5, 1923

20-UNDERTAKER, W. J. Linck — ADDRESS 1837 W. Pratt

Spec.—8-24-14—M. & T.—2000 lbs.

D71994

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 101-001

CERTIFICATE OF DEATH.

D71994

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 Bloom ST.; 14 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adeline Carter

(Residence in Baltimore: No. 435 Bloom St.; ..... yrs., 1 mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, October 1, 1866
(Month) (Day) (Year)

7-AGE, 56 yrs. 4 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Louis Carter

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Pantenow

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. H. Fitzhugh

(Address) 435 Bloom St

FEB 4 - 1923

Filed ..... 191.....

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 2, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 24 1923, to Feb 2 1923
that I saw h Er alive on Feb 1 1923
and that death occurred, on the date stated above, at 9A m.
The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

(Duration) 1 wk. yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 11 ds.

(Signed) H. S. McCard M. D.

2/3, 1923 (Address) 2005 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Virginia

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, Feb 4, 1923

20-UNDERTAKER Wm. H. Pace Sons

ADDRESS Madison & Mosher

Spec.—1-10-21—M&T—1500 Bks.

D71995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D71995

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 573 W 25th St ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Catherine Englehardt

(a) RESIDENCE NO. 573 W 25th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12 1923

7 AGE — Years — Months — Days: 23 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm Englehardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Lucie Kunz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm Englehardt (Address) 573 W 25th St

15 Filed 1923 19 JOHN R. KRAUTH, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1923, to Feb 4, 1923, that I last saw h[illegible] alive on Feb 3, 1923, and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. S. Carter, M. D.

2-4, 1923 (Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Feb. 5 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 552 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71996

CERTIFICATE OF DEATH.

100-002

D71996

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 South Smallwood St., WARD)

2-FULL NAME Myrtle M. Heatley

(a) RESIDENCE NO. 709 South Smallwood ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): June 27 1921

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or min.
1	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): infant

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Albert H. Heatley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Somerset Co. Md

12 MAIDEN NAME OF MOTHER: Myrtle M. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Albert H. Heatley

(Address): 709 S. Smallwood Ave

15 FEB 4 - 1923

ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 27, 1923, to Feb 4, 1923,

that I last saw her alive on Feb 3, 1923

and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Capillary bronchitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): asphyxia + Toxemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. V. Wright, M. D.

2/4, 1923 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: 2/6 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 701 E Nath

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D71997

HEALTH DEPARTMENT—CITY OF BALTIMORE

D71997

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

City of BALTIMORE: (No. 1311 Madison Ave St., 11 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine F. Stevens

(Residence in Baltimore: No. 1311 Madison Ave St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, July 7th, 1858
(Month) (Day) (Year)

7-AGE, 64 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, William Fox

11-BIRTHPLACE OF FATHER, (State or Country), Scotland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rev. Frank Ames

(Address) 400 N Ridgewood Ave

15- Filed FEB 4 1923 192.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 2, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) D. F. Hennessy M. D.
(Coroner.)

Feb. 4 1923 (Address) 502 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt. Olivet Cem DATE OF BURIAL. Feb. 5 1923

20-UNDERTAKER. Wm. Cook ADDRESS 502 E. North Ave

Spec.—1-10-21—M&T—1500 Bks.

71988 D71998

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

71998 D71998

1-PLACE OF DEATH Miss Tyree Nursing Home 65

REGISTERED NO.

CITY OF BALTIMORE: (No. Chase & Calvert St., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May morehouse

(a) RESIDENCE NO. Columbus Ohio ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ mrs Imogene Hull morehouse

6 DATE OF BIRTH (month, day, and year) Oct 15 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	57	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employe

9 BIRTHPLACE (city or town) (State or country) Elyria Ohio

PARENTS

10 NAME OF FATHER Andrew morehouse

11 BIRTHPLACE OF FATHER (city or town) Ohio (State or country)

12 MAIDEN NAME OF MOTHER Edith Brown

13 BIRTHPLACE OF MOTHER (city or town) Ohio (State or country)

14 Informant May Morehouse (Address) 1601 Hawthorne Ave

15 FEB 5 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1923 to Feb. 4, 1923

that I last saw him alive on Feb. 4, 1923

and that death occurred, on the date stated above, at 11:10 a.m.

The CAUSE OF DEATH* was as follows:

Aleukemic myeloid leukemia

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? typical blood work.

(Signed) Norman B. Cole, M. D.

Feb 4. 1923 (Address) 1035 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Columbus Ohio — DATE OF BURIAL Feb 4 1923

20 UNDERTAKER H Jenkins & Sons — ADDRESS Orchard & Frankfort

Spec.—1-10-21—M&T—1500 Bks.

D71999 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D71999

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ... ST., 25 WARD)

2-FULL NAME Norman Guilfoy

(a) RESIDENCE No. 217 E Henry St ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16 - 922

7 AGE: Years — Months 1 — Days 17 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Irvin Guilfoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Blanche ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Record.

(Address)

15 Filed FEB 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1923, to Feb 3, 1923, that I last saw him alive on Feb 3 - 1923, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Prematurity.
Malnutrition.

(duration) — yrs. 1 mos 26 ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) H. H. Mecd M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A & Co md — DATE OF BURIAL: Feb 5 1923

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D72000

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72000

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 111 (ST.,) Cherry Curtis Bay (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Bumba

(a) RESIDENCE NO. 111 (ST.,) Cherry (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15/852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	70	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Don't Know Bohemia

PARENTS

10 NAME OF FATHER Jacob Bumba

11 BIRTHPLACE OF FATHER (city or town) Don't Know (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Mary Matec

13 BIRTHPLACE OF MOTHER (city or town) Don't Know (State or country) Bohemia

14 Informant Mary Kosar

(Address) 111 Cherry st Curtis Bay

15 Filed FEB 5 - 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1923 to Feb. 3, 1923,

that I last saw him alive on Feb. 2nd, 1923,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? N V Date of -

Was there an autopsy? No

What test confirmed diagnosis? Given

(Signed) William D. Scott, M. D.

, 19 (Address) 816 Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross, A A Co Md

DATE OF BURIAL Feb 6 1923

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72001

CERTIFICATE OF DEATH.

D72001

111-00

1-PLACE OF DEATH

REGISTERED No.

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Edward Hyman

(a) RESIDENCE. No. 2038 E. North Ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): March 16 1887

7 AGE: Years 35 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer): City

(c) Name of employer: Superintendent Schools

9 BIRTHPLACE (city or town) (State or country): Balt.

PARENTS

10 NAME OF FATHER: Samuel Hyman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt.

12 MAIDEN NAME OF MOTHER: Mina Brauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt

14 Informant: Samuel Hyman

(Address): 2038 E. North ave

15 Filed FEB 5 - 1923 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1923, to Feb. 2, 1923

that I last saw him alive on Feb. 2, 1923

and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Ruptured Duodenal Ulcer

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): General peritonitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Feb. 2-1923

Was there an autopsy? not

What test confirmed diagnosis? Operation.

(Signed) J. V. Szczubicki, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Feb. 5 19

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Hayford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

73001

1-PLACE OF DEATH

(CITY OF BALTIMORE; (NO. St. Josephs Hospital. ST. 27-43 WARD 210 E 00

2- FULL NAME Frederick Shore.

(a) RESIDENCE NO 3030 Northern Parkway. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. ... mos. How long in U. S., if of foreign birth? 41 yrs. ...

(If non-resident give city or

REGISTERED

(If death o
pital or ins
NAME Inste
number and

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Carrie J. Shore.

6 DATE OF BIRTH (month, day, and year) December 31, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	9	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Government Inspector
(b) General nature of industry, business, or establishment in which employed (or employer) Edgewood Arsenal.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER William Shore.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Mary A. Huntington.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Carried J. Shore. (wife)

(Address) 3030 Northern Parkway.

15 Filed ..... 192 ... Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 16, ...

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of the skull. Accidenta... struck and knocked down by an au... ite white running across the st...

(duration) ... yrs. ... mos ...

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mo...

18 Where was disease contracted if not at place of death? in front of 3030 North... Parkway, Oct. 15, 193...

Did an operation precede death? No. Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Inquest

(Signed) ... Coroner

10/1... (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violen... state (1) Means and Nature of Injury, and (2) whether Suicidal, ... Homicidal. (See reverse side for additional space.)

... L, CREMATION OR RE- | DATE O...

OCT 16 1931

RESERVED FOR BINDING INK—THIS IS A PERMANENT RECORD. Every l... should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS ... mation about AGE should be carefully supplied. AGE should ... CAUSE OF DEATH in plain terms, so that it may b... TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Cosimo Cuomo

D72002

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D72002

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3927 E. Lombard St., (Ward) 76

2-FULL NAME Filippo Cuomo

(a) RESIDENCE NO. 3927 E. Lombard St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Luisa Pisacane

6 DATE OF BIRTH (month, day, and year) March 24-1874

7 AGE 48 Years 10 Months 9 Days | If LESS than 1 day, ...hrs. or .....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commercial

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Antonio Cuomo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maddalena Amadeo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Luisa Cuomo

(Address) 3927 E. Lombard St.

15 Filed FEB 5 1923, 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-2 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-23-, 1923, to 2-2, 1923.

that I last saw h[illegible] alive on 2-2, 1923

and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

acute nephritis

(duration) ..... yrs. mos 10 ds.

CONTRIBUTORY (Secondary) myocardial insufficiency (duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no Primary

What test confirmed diagnosis? Clinical

(Signed) J. Dinaro, M. D.

, 19 (Address) 1604 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem | DATE OF BURIAL 2/5/23, 19

20 UNDERTAKER Geo. J. Puth | ADDRESS 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probable Lobar Pneumonia
+ Cholecystitis

Spec.—1-10-21 M&T 1500 Bks.

(Sciabarasso)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72003

CERTIFICATE OF DEATH.

11-001

D72003

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1039 Harford av ST., 40 WARD)

2-FULL NAME Luigi Sciabarasso

(a) RESIDENCE No. 1039 Harford ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Marchino Rizzo

6 DATE OF BIRTH (month, day, and year): Nov. 30 - 1850

7 AGE: 72 Years 2 Months 5 Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Giuseppe Sciabarasso

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rosalinga Graneto

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Giuseppe Sciabarasso

(Address): 1039 Harford ave

15 Filed FEB 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Febr 4th 19 23

17 I HEREBY CERTIFY, That I attended deceased from Febr 1st, 19 23, to Febr 4, 19 23

that I last saw h alive on Febr. 3rd, 19 23,

and that death occurred, on the date stated above, at 4 30 p.m.

The CAUSE OF DEATH* was as follows:

acute bronchitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Lentz M.D.

, 19 (Address) 210 Pearl st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem't

DATE OF BURIAL: Feb 7, 23

20 UNDERTAKER: George F. Ruth

ADDRESS: 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Influenza 8 days.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72004

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72004

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2658 Frederick av ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary E. Hook

(a) RESIDENCE. No. 2658 Frederick av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs — mos. — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel A Hook

6 DATE OF BIRTH (month, day, and year) Dec 24/1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mary J. Hook 661 S. Dundalk St

15 Filed FEB 5 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 3 1923

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1923, to February 3, 1923, that I last saw her alive on February 2, 1923, and that death occurred, on the date stated above, at 8:45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Senility 1 yr mos. ds.

CONTRIBUTORY (Secondary) Endocarditis Pulmonary

Verified (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Mebel, M. D.

2/4, 1923 (Address) 207 Wilkens ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Feb 5th 19 23
20 UNDERTAKER	ADDRESS
F. B. Hepperd	2236 Frederick ave

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See Letter attached)

D72005 HEALTH DEPARTMENT—CITY OF BALTIMORE D72005

11-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Rehsen Home for Chronic Ill

CITY OF BALTIMORE: (No. 2100 E Baltimore ST., 13 WARD)

2-FULL NAME Fannie Rosen

(a) RESIDENCE No. 3404 Morris ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) old age

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Louis 1439 E Balto

15 FEB 5 - 1923 RUDOLPH R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1923, to Feb. 4, 1923, that I last saw her alive on Feb. 4, 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H J Bayliss M. D.

2/5, 1923 (Address) 210 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehsen Wash Rd

DATE OF BURIAL 2/5 1923

20 UNDERTAKER Jack Levis 1439 E Balto

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DR. M. J. BAYLIN
212 AISQUITH STREET
BALTIMORE, MD.

3/12/03

Dr C Hampson Jones,
Commissioner of Health
Balto. Md.

Dear Sir. -

Kindly look up & give
in the Death Certificate of Daniel Rosen
No. 18310) from 80 to 67.

Respectfully

E J Baylin Jr

Spec.—1-10-21—M&T—1500 Bks.

Manger

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72006

CERTIFICATE OF DEATH.

X 88

D72006

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Morrow Hospital ST., 16 WARD)

2-FULL NAME Harry A. Manger

(a) RESIDENCE NO. Westminster Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21 1904

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
18	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer) Plastering

(c) Name of employer For Father

9 BIRTHPLACE (city or town) (State or country) Westminster Md

PARENTS

10 NAME OF FATHER Howard Manger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary M Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant A. Howard Manger

(Address) Westminster Md.

15 Filed FEB 5 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 4 1923

17

I HEREBY CERTIFY, That I attended deceased from 1 - 15 , 1923, to 2 - 4 , 1923,

that I last saw him alive on 2 - 4 , 1923

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis acute

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) P. E. Schools, M. D.

, 19 (Address) Morrow Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md — DATE OF BURIAL Feb. 5 - 1923

20 UNDERTAKER Wm. Crole — ADDRESS 502 E. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72007 CERTIFICATE OF DEATH. D72007

101-001

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. 917 Peach Alley. St., 23 Ward)

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Meyers. (C)

(Residence in Baltimore: No. 917 Peach Alley. St.; yrs. 12 mos. ds.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: Colored.

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Do not know. (Month) (Day) 1 (Year)

7-AGE: 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer.
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Missouri.

PARENTS.

10-NAME OF FATHER: Do not know.

11-BIRTHPLACE OF FATHER, (State or Country): Do not know.

12-MAIDEN NAME OF MOTHER: Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country): Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eleanore Little. (C)

(Address) 917 Peach Alley.

15- FEB 5 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 2nd. 1923. (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Feb. 2nd. 192 3 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: JOHNS HOPKINS HOSPITAL. DATE OF BURIAL: ... 19...

20-UNDERTAKER: Commissioner Health, ADDRESS FEB 3 - 1923

Wm. E. WOODALL

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72008

D72008

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH Southern Hospital.

CITY OF BALTIMORE: (No. 2520 Greenmount Ave. ST.; 15 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E Hepperla.

(Residence in Baltimore: No. 3305 Carlisle Ave Forest Park. St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov. (Month) 17 (Day), 1866 (Year)

7-AGE, 56 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Henry Hepperla.

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Louisa Goale

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Hepperla

(Address) 3305 Carlisle Ave Forest Park

15-

Filed DEC 5 - 1923, 191... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 3 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 8 1918, to Feb. 3 1923 that I saw her alive on Feb. 2 1923 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast and Thorax

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Feb. 4, 1923 (Address) 2226 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. 3 mos. 2 ds. In the State 30 yrs. mos. ds.

Where was disease contracted, if not at place of death? her home, Baltimore Md

Former or usual residence 3305 Carlisle ave.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, Feb. 5, 1923

20-UNDERTAKER [illegible] ADDRESS [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE WITH PEN AND INDELIBLE INK—THIS IS A PERMANENT RECORD

D72009

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

V 102-001

D72009

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3100 Clifton Ave St. 15 WARD)

(If death occured in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William Henry Purcell

(Residence in Baltimore: No. 3100 Clifton Ave St.: 35 yrs. ? mos. ? ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: August (Month) 6 (Day), 1849 (Year)

7 AGE: 73 yrs. 5 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Insurance Agt.
(b) General nature of industry, business, or establishment in which employed (or employer): Mutual Fire Ins Co

9 BIRTHPLACE (State or country): Ireland

PARENTS

10 NAME OF FATHER: Wm. H. Purcell

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Harriet Sweetman

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Belle C. Purcell (wife)

(Address) 3100 Clifton Ave.

15 FEB 5 - 1923 Filed ....., 191.... ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. (Month) 3 (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1923 to Feb. 3 1923 that I saw h[illegible] alive on Feb. 3, 1923 and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — yrs. — mos. 9 ds

Contributory (Secondary) Myocarditis; Arterio-Sclerosis (Duration) 3 yrs. — mos. — ds.

(Signed) H. A. Dodd M. D.

Feb. 3, 1923 (Address) 3101 Clifton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park Cemy

DATE OF BURIAL: Feb. 5, 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH AVE

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72010

CERTIFICATE OF DEATH.

101-001

D72010

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 Robert St ST., 14 WARD)

2-FULL NAME Mary Summerville

(a) RESIDENCE NO. 522 Robert St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer: Mrs. Louis Muth

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: William Summerville

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ann Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Summerville

(Address): 522 Robert St

15 Filed FEB 5 - 1923 ROBERT R. KRAUTER, Assistant Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 30, 1923, to July 4, 1923

that I last saw h.. alive on July 4, 1923

and that death occurred, on the date stated above, at 5 A m

The CAUSE OF DEATH* was as follows:

Robert Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chr Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

(Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Louis F Columbus M. D.

July 4 1923 (Address) 150 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: July 7th 1923

20 UNDERTAKER: Chas. E. Wright — ADDRESS: 1364 N. Carey

D72011 D72011

D72011 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. ..... St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Taylor

(Residence in Baltimore: No. 1120 Elon St St.; yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	Col	

6-DATE OF BIRTH. ..... 1.....
(Month) (Day) (Year)

7-AGE, 40 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Benj. Taylor

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Laura —

13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15-Filed FEB 5 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 2 23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held un..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed).....M. D.
(Coroner.)

..... 192....(Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Branch DATE OF BURIAL, Feb 6 1923

20-UNDERTAKER, John H Ivadier ADDRESS 142 Utica St

D72012

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 101-001

D72012

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1108 Russell St. St. ..... Ward)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida R. Gross. (C)

(Residence in Baltimore: No. 1108 Russell St. St.; yrs. 53 mos. 1 ds. ----)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female.	Colored.	Married.

6-DATE OF BIRTH. January 2nd. 1870. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
53 yrs. 1 mos. ---- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Charles Williams. (C)

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Mary H. Palmer. (C)

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Gross. (C) husband.

(Address) 1108 Russell St.

15- FEB 5 - 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. February 2nd. 1923. (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto H. Pennhascl (Coroner.)

Feb. 2nd. 192 3 (Address) 917 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn

DATE OF BURIAL. Feb. 5 192 2

20-UNDERTAKER. John N. Tondin

ADDRESS 1112 W. Hillsf

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72013

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D72013

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 S. Ellwood Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Nelson

(a) RESIDENCE No. 813 S. Ellwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Emma L. Nelson

6 DATE OF BIRTH (month, day, and year) Nov 8/77

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Olaf Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Louisa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Emma L. Nelson

(Address): 813 S Ellwood

15 Filed FEB 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/2 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2 1923 to Feb 1st 1923, that I last saw h[illegible] alive on Feb 1st 1923, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Exploratory

Was there an autopsy? Yes

What test confirmed diagnosis? Exploratory operation

(Signed) H. B. Kelly M. D.

2/3, 1923 (Address) 2504 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL 2/5 192[illegible]

20 UNDERTAKER: Philip Henry — ADDRESS 201 Orleans

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72014

CERTIFICATE OF DEATH.

57 D72014

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 S. Ann ST., 7 WARD)

2-FULL NAME Mary Dillfelder

(a) RESIDENCE NO. 731 S. Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: George Dillfelder

6 DATE OF BIRTH (month, day, and year): Apr 754

7 AGE: Years 68, Months 9, Days —, If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Henry Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: George Dillfelder

(Address) 731 S. Ann St

FEB 5 - 1923 ROBERT R. KRAUER, Registrar

~~Burial Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/3 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1922 to Feb. 3, 1923.

that I last saw h alive on Feb. 2, 1923,

and that death occurred, on the date stated above, at 2 40 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine.

(Signed) E. L. Cassard M. D.

Feb. 4, 1923 (Address) 2en Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Cem.

DATE OF BURIAL 2/6 1923

20 UNDERTAKER: Philip Hennig

ADDRESS 201 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72015

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D72015

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2136 Fred Ave ST., 20 WARD)

2-FULL NAME George Stump

(a) RESIDENCE NO. 2136 Fred Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 10 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Stump

6 DATE OF BIRTH (month, day, and year) May 17-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cattle Dealer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Konrad Stump

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Martha Hess

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs. Maggie Stump
(Address) 2136 Fredrick Ave

15 FEB 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to Feb 1, 1923,

that I last saw h[illegible] alive on Feb 1, 1923

and that death occurred, on the date stated above, at 2:00 m

The CAUSE OF DEATH* was as follows:

Carcinoma of Urinary Bladder

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw R Carsloken, M. D

2/3, 1923 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Feb 5 1923

20 UNDERTAKER George E. Schmab ADDRESS 2101 Pratt St

Spec.—1-10-21—M&T—1500 Bks.

D72016

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D72016

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 N. Gilmor ST., 19 WARD)

2-FULL NAME ~~Harrison~~ Thomas Harrison

(a) RESIDENCE NO. 327 N Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer 640

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Matter not.

9 BIRTHPLACE (city or town) (State or country) Matter not.

PARENTS

10 NAME OF FATHER James Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) not

12 MAIDEN NAME OF MOTHER Annie Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not

14 Informant Della Boston
(Address) 1620 N Gaston ave

15 FEB 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 27 - , 1923 , to Feb 2 - , 1923.

that I last saw him alive on " " , 19 " ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) debility exposure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J H Cardey M. D.

2-4-23 (Address) 1524 Druid Hill ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL Feb 5 19 23

20 UNDERTAKER Brown & Richardson ADDRESS 1140 N

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72017

D72017

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 Sarah Ann ST.; 18 WARD)

2-FULL NAME Sophie Batty

(a) RESIDENCE. NO. 1115 Sarah Ann ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fm

4 COLOR OR RACE: Col

5 ~~Single, Married,~~ Widowed. ~~or Divorced~~ (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~and~~ WIFE of: Chas. A. Batty

6 DATE OF BIRTH (month, day, and year): 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Thomas Handy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

11 Informant: Sophia Scibner

(Address) 1115 Sarah Ann St.

15 FEB 5 - 1923 ROBERT R. KRAUTER, Registrar

Deputy Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 1 192

17 I HEREBY CERTIFY, That I attended deceased from May 23 1922, to Jany 1 1923

that I last saw her alive on Jany 1 1923

and that death occurred, on the date stated above, at 220 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) David Murray Hott, M. D.

2 2, 1923 (Address) 1776 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Feb 5 19

20 UNDERTAKER: Brown & Pleasants

ADDRESS 114

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72018 160-001 D72018

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Volunteers of America Hosp

CITY OF BALTIMORE: (No. 418 W. Lexington ST.; 17 WARD)

2-FULL NAME Mary E. Griffin

(a) RESIDENCE. NO. 667 N Franklin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE — Years: 53 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER Michl. Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Cath. Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: George Griffin (Address) 1809 W. Lexington st

15 Filed FEB 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/4 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1923, to Feb 4, 1923, that I last saw he alive on Feb 4, 1923, and that death occurred, on the date stated above, at 5.40 Am

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) C. Richardson Coyne M. D.

. 19 (Address) 418 W. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Feb 6 1923

20 UNDERTAKER: F. A. Krause & Son — ADDRESS: 703 Hanover

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every ... state C... is very

(Address) 419 N. Brice St.

15-
Filed JAN 23 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

Former or usual residence Ohio

19-PLACE OF BURIAL OR REMOVAL. Cincinnati Ohio — DATE OF BURIAL, Jan 23 192

20-UNDERTAKER F. A. Krause & Son — ADDRESS 1103 Hanover Pace

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72019

CERTIFICATE OF DEATH

90 D72019

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5305 Melvin ave ST.) Delivery (27 WARD)

2-FULL NAME Joanna F. Hamilton

(a) RESIDENCE. NO. 5305 Melvin ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Frank Hamilton

6 DATE OF BIRTH (month, day, and year) May 6 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Stansbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Stricker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. F. Hamilton (Address) 5305 Melvin ave

15 Filed FEB 5 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 2, 1923, that I last saw h[er] alive on Feb 1, 1923, and that death occurred, on the date stated above, at 10.35 A m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Asthma

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas J Mills, M. D.

, 19 (Address) 2 W Belvedere ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Feb 5 1923

20 UNDERTAKER F. A. Krause & Son — ADDRESS 703 Hanover

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Valvular Heart Disease
& Bronchial
Park Heights
+ Belvedere
Dr. Well
Madison + Wheelock

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72020 100-001 D72020

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Claire Virginia Darby

(Residence in Baltimore: No. 2910 Clifton Ave. St.; yrs., 1 mos. 13 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) single

6-DATE OF BIRTH, Dec. 21 (Month) (Day) 1922 (Year)

7-AGE, ...yrs. 1 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Frank W. Darby

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Alice B. Beard

13-BIRTHPLACE OF MOTHER, (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. W. Darby

(Address) 2910 Clifton Ave.

15-

Filed FEB 5 - 1923 19.. ROBERT N. KRAUTER Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 3 (Month) (Day) 192[illegible] (Year)

17- I HEREBY CERTIFY, That I took charge of the 2 remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) ms history

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Feb. 5 1923 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lorraine

DATE OF BURIAL, FEB 6 1923

20-UNDERTAKER, Geo W. Little

ADDRESS 2700 Edmondson Ave.

D72021

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72021

CERTIFICATE OF DEATH.

Registered No. C 6 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 2207 Mulliken St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill ont No. 18.)

2-FULL NAME Nannie Walton Champness

(Residence in Baltimore: No. 2207 Mulliken St.; yrs. 25 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK. THIS BLANK MUST NOT BE FOLDED.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

6-DATE OF BIRTH: April (Month) 17 (Day) 1877 (Year)

7-AGE: 45 yrs. 9 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Cambridge Md

PARENTS.

10-NAME OF FATHER, Wm Tayor

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Sarah Dickins

13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George W. Champness

(Address) 2507 E. Fayette St

15-Filed FEB 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 2 (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from mouth

Pulmonary Tuberculosis

History of (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 8 months loss of weight (Duration) 2 yrs. mos. ds.

(Signed) J. H. Baker M. D.
(Coroner.)

2-3 1923 (Address) 508 E. Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loram Cemetery — DATE OF BURIAL, Feb 5 1923

20-UNDERTAKER, Robt J Turner Sr. — ADDRESS 1402 N Broadway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

D72022

REGISTERED NO. D72022

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 S. Bouldin St., No WARD)

2-FULL NAME Louis Augle

(a) RESIDENCE No. 424 S. Bouldin St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 10, 1850

7 AGE: Years 72 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundry Mgr

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unk Kunn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unk Kunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Edward Augle (Address) 424 S Bouldin St

15 Filed FEB 5 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 4 1923

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1923, to February 3, 1923, that I last saw him alive on February 3, 1923, and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J Ayd, M. D.

Feb 23, 19 (Address) 2005 E Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Pleasant Cemetery — DATE OF BURIAL: Feby 6, 1923

20 UNDERTAKER: Robt J Turner Sons — ADDRESS: W. Baltimore

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72023 D72023

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 760 Redwood ST., 14 WARD)

2-FULL NAME Benjamin J. Hyman

(a) RESIDENCE NO. 760 Redwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 55 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shochet

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Barell Hyman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: B. Hyman
(Address) 760 Redwood st

15 FEB 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb, 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec, 5, 1920, to Feb, 4, 1923,

that I last saw him alive on Feb, 4, 1923,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis,

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) arterio sclerosis, Emphysema

Chr. Interstitial Nephritis - (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Dave Franklin, M. D.

2/4, 1923 (Address) 1122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 1/5 1923

20 UNDERTAKER: S. Levinson & Bro — ADDRESS 1127 E Balto St

D72024 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D72024

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. John Hopkins ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses Friedman

(Residence in Baltimore: No. 1129 E Lombard st St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK. N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ... January (Month) 26 (Day), 1922 (Year)

7-AGE, 1 yrs. 11 mos. ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto md.

PARENTS.

10-NAME OF FATHER, Manahan Friedman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Ethel Freeman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Friedman

(Address) 1129 E. Lombard st

15-

Filed....., 191. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

FEB 5 - 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July 4 (Month) (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) .....yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Collins M. D.
(Coroner.)

7-4-1922 (Address) 506 N. Monroe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rising Sun | DATE OF BURIAL, 2/5, 1923

20-UNDERTAKER J. Lanzer & Bro. | ADDRESS 1127 E Balto St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Leizear

D72025

101-001 V

CERTIFICATE OF DEATH.

D72025

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 S. Gilmor ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. R. Leizear

(Residence in Baltimore: No. 219 S. Gilmor St St.: 54 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Widower

6-DATE OF BIRTH, June (Month) 25th (Day), 1855 (Year)

7-AGE, 67 yrs. 7 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Miller
(b) General nature of industry, business, or establishment in which employed (or employer): (Flour)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas. Leizear

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER —— Dural

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles R. Leizear Jr.

(Address) 219 S. Gilmor St

15- Filed FEB 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 3rd (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1923, to Feb 3rd 1923, that I saw him alive on Feb 2nd 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Following Influenza

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) yrs. 2 mos. ds.

(Signed) Leonard McCaskey M. D.

Feb 4th 1923, (Address) 1114 Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, Feb 5, 1923

20-UNDERTAKER Harry A. Witzke ADDRESS 531 W Lombard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK, IN THE [illegible]

Spec.—6-9-19—H. P. Co.—1000 Blks.

D72026

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 S. Monroe St. ST.: 20 WARD)

REGISTERED NO. 129 D72026

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gesine Tobias

(a) RESIDENCE. No. 626 S. Monroe St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or WIFE of) The late Gerhard Tobias

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Hasloop

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gretchen Hasloop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. C. A. Harding 626 S. Monroe St.

15 FEB 5 - 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1922, to Feb 2, 1923, that I last saw h[illegible] alive on Feb 2, 1923, and that death occurred, on the date stated above, at 1.10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A Hellen Hemming M. D.

2/4. 1923 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Feb. 5 1923

20 UNDERTAKER: Harry N. Witzke — ADDRESS: 1581 W. Lombard

D72027

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D72027

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 517 Jasper St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilda N. Butler

(Residence in Baltimore: No. 517 Jasper St. St.; yrs. 2 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	colored	single

6-DATE OF BIRTH. Nov. 24 1922
(Month) (Day) (Year)

7-AGE. ....yrs. 2 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): (Dependent)

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. John Butler

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Ella Russell

13-BIRTHPLACE OF MOTHER. (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Butler

(Address) 517 Jasper St.

15- Filed FEB 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 2 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Feb 5 1923 (Address) 3502 Edmondson Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn — DATE OF BURIAL. Feb 5 1923

20-UNDERTAKER. R. B. Gross — ADDRESS 405 McElderry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY. WITH

Spec.—1-10-21—M&T—1500 Bks.

KNOX

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72028

CERTIFICATE OF DEATH.

101-001

D72028

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 Pearce ST., 18 WARD)

2-FULL NAME Daniel Knox

(a) RESIDENCE NO. 913 Pearce ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Va

9 BIRTHPLACE (city or town) ..... (State or country) Henry Knox

PARENTS

10 NAME OF FATHER Va

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Capitol Chamber

12 MAIDEN NAME OF MOTHER Va

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country)

14 Informant Mrs J Meyers
(Address) 913 Pearce St

15 FEB 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Feb 5, 1923,

that I last saw h... alive on Feb 2, 1923,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) acute endocarditis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wm Hemmeter, M. D.

2, 19 23 (Address) 1002 Farnum ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 2-5 1923

20 UNDERTAKER David Easton — ADDRESS 916 Pa ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72029

CERTIFICATE OF DEATH.

31 D72029

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Getz.

(a) RESIDENCE No. 3708 E. Lombard St. ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	31	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Getz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 5 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 19 23

17 I HEREBY CERTIFY, That I attended deceased from January 26, 19 23 to February 2, 19 23, that I last saw him alive on February 2nd, 19 23, and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Aut.

(Signed) Clyde Mann M. D.

2/2/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Feb 5 1923

20 UNDERTAKER: Jas L. Miller — ADDRESS: 2334 Jeffers St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72030

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72030

118-002

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 S Luzerne Ave ST.: (WARD)

2-FULL NAME Rosaline M- Zuchowski

(a) RESIDENCE. NO. 811 S Luzerne Ave ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? 4yrs. mos. ds

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 6 1919

7 AGE: Years 3 Months 7 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph Zuchowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Frances Kowpacka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Joseph Zuchowski 811 S Luzerne Ave

15 FEB 5 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 3- 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1923, to Feb. 3, 1923, that I last saw h alive on Feb 3, 1923, and that death occurred, on the date stated above, at 9 30 p.m.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? x

(Signed) Frank S James Jr, M. D.

2/5, 1923 (Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem — DATE OF BURIAL: Feb 6 1923

20 UNDERTAKER: Stephen F Falkowski — ADDRESS: 1008 S Kenwood Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72031

CERTIFICATE OF DEATH. Koerner 24-001

D72031

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1809 N. Patterson Pk Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad Korner

(Residence in Baltimore: No. 1809 N. Patterson Pk Ave St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, Divorced. (Write the word.) Married

6-DATE OF BIRTH. Sept 16 (Month) (Day) 1870 (Year)

7-AGE. 52 yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Coal Yard

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. John Korner

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs George E Koerner

(Address) 1809 N Patterson Pk Ave

15- FEB 5 - 1923 192.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 4 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) J. S. T. Callin M. D. (Coroner.)

2-5 1923 (Address) 548 E Lombard

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cemetery DATE OF BURIAL. Feb 7 1923

20-UNDERTAKER. Henry Horch Sons ADDRESS 1301 E Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72032

CERTIFICATE OF DEATH.

94-061

D72032

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 315 E 31st St ST., 17 WARD)

2-FULL NAME Katherine Hughes

(a) RESIDENCE NO. 315 E 31st St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Ireland

PARENTS

10 NAME OF FATHER Cornelius Hannegan

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Smyth

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Mrs E J Green
(Address) 315 E 31st St

15 FEB 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1923, to Feb 4, 1923,

that I last saw h[illegible] alive on Feb 4, 1923.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Edw. A Carolan, M. D.

2/5, 1923 (Address) 24 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 2/6 1923

20 UNDERTAKER Henry C Browning

ADDRESS 517 N Schroeder St

Spec.--1-10 21--M&T--1500 Blks.

D72033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

52

D72033

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 17 WARD)

2-FULL NAME Anna Carter

(a) RESIDENCE NO. 827 George St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	47	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Andrew Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Anna Rhone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Municipal Hospital Records.

(Address)

15 Filed FEB 5 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 1, 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 10, 19 22, to February 1, 19 23,

that I last saw her alive on January 31, 19 23,

and that death occurred, on the date stated above, at 5:00 A. M.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

2/2/19 23 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: Feb 5 19 23

20 UNDERTAKER: [illegible] ADDRESS [illegible]

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72034

D72034

CERTIFICATE OF DEATH.

44

REGISTERED NO. C.....

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 3524 Beaumont Ave. St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Mathilda Bitter

(Residence in Baltimore: No. 1821 Guilford Ave. St.; 5 yrs., — mos. — ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS SPACE WITHIN BORDER LINE TO BE LEFT BLANK.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~, (Write the word.) Widow

6-DATE OF BIRTH, April (Month) 25 (Day), 1851 (Year)

7-AGE, 71 yrs. 9 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ~~None~~ None
(b) General nature of industry, business, or establishment in which employed (or employer) At Home.

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Frederick Oelmann

11-BIRTHPLACE OF FATHER (State or Country), Germany,

12-MAIDEN NAME OF MOTHER, Boothea Doring

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara L. Schultze

(Address) 3524 Beaumont Ave

15- FEB 5 - 1923 Filed....., 191... ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF ~~DEATH~~, February (Month) 4 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 20 1922, to Feb 3 1923, that I saw h~~e~~r alive on Feb 3 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(Duration) ....yrs. 7 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John K. Mercer M.D.

Feb 4 1923, 191... (Address) 354 Beaumont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Feb 6, 1923

20-UNDERTAKER George Smith

ADDRESS 1732 Holland

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72035

CERTIFICATE OF DEATH.

V 100-001

D72035

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Fulton Ave St.; 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Ella E. Taylor

(Residence in Baltimore: No. Home for the Aged of the M. E. Church St.; 83 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, March (Month) 25 (Day), 1839 (Year)

7-AGE, 83 yrs. 10 mos. 10 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Ed Matthews

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Tabitha Fuller

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Cuddy

(Address) 400 N. Fulton Ave

15-

Filed DEC 5 - 1923, 191.... ROBERT R. KRAUTER,

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Febry (Month) 4 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 24 1923, to Febry 4 1923, that I saw her alive on Febry 4 1923, and that death occurred, on the date stated above, at 8 15 p. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) 1 yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Pericarditis

(Duration) 1 yrs. 1 mos. ds.

(Signed) George C Shannon M. D.

2/4, 1923 (Address) 700 Fulton ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Feb. 6, 1923

20-UNDERTAKER George J. Smith

ADDRESS 1532 Hollins

D72036 HEALTH DEPARTMENT--CITY OF BALTIMORE 29 D72036

CERTIFICATE OF DEATH

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 400 N. Fulton Ave St. 20 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Eliza E. Turner

(Residence in Baltimore: No. Home for the Aged of the M.E. Church St.; 78 yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: December 2, 1845 (Month) (Day) (Year)

7-AGE: 77 yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: John Washington Turner

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Mary E Tanthran

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E Mahaddy

(Address) 400 N Fulton Ave

FEB 5 - 1923 Filed, 191 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Febry 4, 1923. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 31, 1923, to Febry 4 1923.

that I saw h- alive on Febry 4 1923.

and that death occurred, on the date stated above, at 4 15/ p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) Endocarditis.

(Duration) yrs. mos. ds.

(Signed) George C. Brennan M. D.

2/7, 1923 (Address) 700 Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: Feb 6 1923

20-UNDERTAKER: George J Smith

ADDRESS 1532 Hollins st

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72037

CERTIFICATE OF DEATH.

D72037

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 213 N. Schroeder ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Smith

(a) RESIDENCE. NO. 213 N. Schroeder ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 2, 1923

7 AGE — Years — Months — Days: 2 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Ethel Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant (Address): Mother

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 2 1923 to Feb 4 1923, that I last saw him alive on Feb 4 1923, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Premature birth
(37 Wks)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. Norwood Wilson, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER

Commissioner Health.

Per. Wm. A. WOODALL

FEB 5 - 19

FEB 5 - 1923

Burial Permit Granted

4

M. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D72038 HEALTH DEPARTMENT—CITY OF BALTIMORE D72038

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Tilghman

(a) RESIDENCE No. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	89	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records. (Address)

15 FEB 5 - 1923 Robert P. Harrison, Registrar

Burial Permit Clerk?

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 19 23

17

I HEREBY CERTIFY, That I attended deceased from April 11, 19 14, to February 2, 19 23, that I last saw him alive on February 1, 19 23, and that death occurred, on the date stated above, at 4:30 A. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Terminal Broncho-pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde Marvell, M. D.

2/2, 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

FEB 5 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72039 D72039

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Boyview Hospital

CITY OF BALTIMORE: (No. 16 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Russum

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 687

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Do

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Boyview Hospital Balto Md.

15 Filed 1923 Robert F. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1923 to Feb. 2, 1923

that I last saw h[illegible] alive on Feb 1, 1923 at 7.30 p. m.

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebro Spinal Fever

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) N. P. Smith, M. D.

, 19 (Address) Boyview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. — ADDRESS

Asst. Wm. S. McCULLY

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72040 ✓ 161-001 D72040

D72040

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1014 S. Fremont ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Ferguson

(a) RESIDENCE. NO. 1014 S. Fremont ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1923

7 AGE — Years — Months — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 0 0 0

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Pat Ferguson

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Blanche Ferguson

13 BIRTHPLACE OF MOTHER (city or town) Norfolk Va
(State or country)

14 Informant Mother
(Address) JOHNS

15 Filed 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1923, to Feb 4, 1923, that I last saw h alive on Feb 4, 1923, and that death occurred, on the date stated above, at 9:00 A m.

The CAUSE OF DEATH* was as follows:

(a) Prematurity
27 (wks)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. Harwood Wilson M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health,

ADDRESS FEB 5 - 192

FEB 5 1923

0091

Spec.—1-10-21—M&T—1500 Bks.

D72041 HEALTH DEPARTMENT—CITY OF BALTIMORE D72041

74-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 719 Ensor ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Wright

(a) RESIDENCE NO. 719 Ensor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. H. Wright

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
63	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City Maryland

PARENTS

10 NAME OF FATHER Perry Daniels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Nancy Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Jessie Hyson

(Address) 719 Ensor St

15 Filed DEC 5 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 2-1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13-, 1922, to February 2, 1923, that I last saw her alive on February 1, 1923, and that death occurred, on the date stated above, at 5.05 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Paralysis & Bright Disease (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Paralysis & Bright Disease (duration) yrs. 6 mos. 19 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. S. W. Kennard M. D.

2-2, 1923 Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Feb 6 1923

20 UNDERTAKER Chas G. Bailey

ADDRESS 1721 Jefferson

B.—WRITE PLAINLY with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. Physicians CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72042

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72042

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. ... ST., 14 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Bush

(a) RESIDENCE NO. Woodland, California ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be answered. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Woodland, Cal.

PARENTS

10 NAME OF FATHER C. W. Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Miss

12 MAIDEN NAME OF MOTHER Lucy Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Missouri

14 Informant (Address) C. Nelson Hockett, Woodland Cal.

15 Robert F. Harrison, Burial Permit Clerk.

Filed ..... 19 ..... Registrar

SEP 5 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1922, to February 5, 1923.

that I last saw h alive on February 5, 1923.

and that death occurred, on the date stated above, at 1-15 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) about yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) invalid

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? California.

Did an operation precede death? yes Date of Dec 9, 1922

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Edwin B. Jarrett, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacramento Cal

DATE OF BURIAL Feb 5 1923.

20 UNDERTAKER A. Jenkins & Co

ADDRESS Oakland

Spec.—1-10-21—M&T—1500 Bks.

Kennedy

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72043

CERTIFICATE OF DEATH.

101-002 D72043

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 St. Joseph) ST., 8 WARD)

2-FULL NAME Carroll Kennedy

(a) RESIDENCE NO. 1633 St. Joseph ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7-1-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Burrell Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Helen Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. Helen Kennedy
(Address) 1633 St. Joseph Ave.

15 Robert P. Harrison, Registrar
FEB 5 - 1923 . 19 ..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1923, to Feb. 4, 1923, that I last saw him alive on Feb. 3, 1923, and that death occurred, on the date stated above, at 10 91 m.

The CAUSE OF DEATH* was as follows:

Capillary bronchitis

(duration) ..... yrs. ..... mos. ½ ds.

CONTRIBUTORY (Secondary) Bronchitis (acute)

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jacob Robinson, M. D.

2/5, 1923 (Address) 1520 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL Feb. 6 1923

20 UNDERTAKER Wm J. G. Locke

ADDRESS 1302 Jefferson St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16129 D72044

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72044 100-001

CERTIFICATE OF DEATH.

5

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

JOHNS HOPKINS HOSPITAL.

2-FULL NAME Francis Parish

(a) RESIDENCE NO. 731 August St City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Color Lunge

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 29 1898

7 AGE: Years 25 Months ... Days ... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron Porter do
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records
(Address)

15 Filed FEB 5 - 1923 . 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 29 . 1923 . to Feb 1 . 1923.
that I last saw him alive on Feb 1 . 1923.
and that death occurred, on the date stated above, at 4 30 p.m.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Pneumothorax

(duration) yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? .....
(Signed) Edward R Baehr, M. D.
. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fredericksburg Va.

DATE OF BURIAL Feb 3 1923

20 UNDERTAKER Mrs. G. Locks

ADDRESS 302 Jefferson

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ... should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72045

100-001 D72045

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2224 E Fayette ST., 6 WARD)

2-FULL NAME Geo. Brooks Johnston

(a) RESIDENCE NO. 2224 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mollie C. Johnston

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 71; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm. Johnston

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: D. G. Johnston

(Address): Hudson Cement & Supply Co.

15 FEB 5 1923 .19 ROBERT F. BAETJER, Registrar

District Deputy Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 28 .1923. to Feb 4 .1923. that I last saw him alive on Feb 3 .1923. and that death occurred, on the date stated above, at 5.00 A m.

The CAUSE OF DEATH* was as follows:

Bronchо-Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary): Bronchо Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Not Given

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Adam 13 Lennox, M. D.

2/5, 1923 (Address) 718 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL 19

20 UNDERTAKER: Wm. J. Luckner & Son

ADDRESS North Ave.

B. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should give mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72046

91-001 D72046

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 96 WARD)

2-FULL NAME Mary Breckenridge

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	~~White~~ COLORED	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
50	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 5 - 1923, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1922, to February 2, 1923, that I last saw her alive on February 2, 1923, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia of Heart

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

2/3/1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rapidee Hebrew Meml. DATE OF BURIAL Feb. 6 1923

20 UNDERTAKER [illegible] ADDRESS 1313 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic nephritis
Hypertension
B Pressure 210/110
Ph Thalein 16% in 4 hrs
Urine: 1016 - Alb. casts
Wassermann neg.
Autopsy shows aneurysm of heart
No syphilis. Aneurysm due to
infarct or arteriosclerosis

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72047

D72047

CERTIFICATE OF DEATH.

4 101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 640 West Fayette ST., 4 WARD)

2-FULL NAME Harry Charles Cooper

(a) RESIDENCE NO. 640 West Fayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) General work

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs. Annie F. Oliver

(Address) 3405 Edmondson Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 4th. 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1923, to Feb. 4th, 1923,

that I last saw h[illegible] alive on Feb. 4th, 1923,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry H. Weinberger, M. D.

Feb 5, 1923 (Address) 724 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery.

DATE OF BURIAL Feb. 6 1923

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N Balto St

FEB 5 — 1923

Robert F. Harrison,

Chief Permit Clerk.

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72048

CERTIFICATE OF DEATH.

D72048

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1706 Edmondson Ave. (WARD) 16

2-FULL NAME Eliza E. Metz

(a) RESIDENCE NO. 1706 Edmondson Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 10 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ... should be stated EXACTLY. PHYSICIANS should state ... AGE should be carefully supplied. ... that it may be properly classified. Exact statement of OCCUPATION ... CAUSE OF DEATH in plain terms, so ... See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Metz

6 DATE OF BIRTH (month, day, and year) Mch. 8th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Of Home

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Jesse Smith

11 BIRTHPLACE OF FATHER (city or town) St. Michaels (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ethel E. Hutson

13 BIRTHPLACE OF MOTHER (city or town) St. Michaels (State or country) Maryland

14 Informant Frances D. Magill (Address) 1702 Edmondson Ave

15 FEB 5 - 1923, 19 ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 27 1923, to Feb 3 1923.

That I last saw her alive on Feb 3rd 1923

and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

2/4 (Signed) Bernard S. Farrell, M. D.

, 1923 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Feb 6 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Gilmor St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72049

CERTIFICATE OF DEATH.

49 D72049

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1434 Hanover ST. 23 WARD)

2-FULL NAME Thos. H. Gibson

(a) RESIDENCE NO. 1434 Hanover ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Theresa Gibson

6 DATE OF BIRTH (month, day, and year) June 16, 1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
71	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Edw. Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Jos. Gibson (Address) Brooklyn Md

15 ROBT. J. KAPPEL .19

Burial Permit Clerk, Registrar

FEB 5 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4-23 19

17 I HEREBY CERTIFY, That I attended deceased from 10-1-22 .19 .. to 2-4-23 .19 .. that I last saw him alive on 2-3-23 19 .. and that death occurred, on the date stated above, at 2 am m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervical Glands - (left)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Path. Exam. of Specimen of tissue

(Signed) Raw[illegible] Jr. M. D.

2-4-23 19 (Address) 1430 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL Feb. 6 1923

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1422 Light St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D72050

CERTIFICATE OF DEATH

101-001 D72050

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1417 ander St. 24 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Edward T. Johnson

(Residence in Baltimore: No. 1417 ander St. St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (If yes the word)
Male	White	Single

6 DATE OF BIRTH Jan 26, 1923 (Month) (Day) (Year)

7 AGE ..... yrs. ..... mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant-
(b) General nature of industry, business, or establishment in which employed (or employer) ..... (Dead)

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Winfield Johnson

11 BIRTHPLACE OF FATHER (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Selena Macken

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Selena Johnson

(Address) 1417 ander St

15 Robert P. Harrison, 191 Burial Permit Clerk REGISTRAR

FEB 5 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 2, 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1923, to Feb. 5 1923, that I saw him alive on Feb 4, 1923, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

3 ds (Duration) ..... yrs. ..... mos.

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos F. Stevens M. D.

Feb. 5, 1923 (Address) 2878 Hartford

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Cedar Hill Cem DATE OF BURIAL Feb. 6, 1923

20 UNDERTAKER Margaret J. Flynn ADDRESS 1422 Light

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72051

D72051

CERTIFICATE OF DEATH.

11-00

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1614 Pennington ave ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmine Raber

(a) RESIDENCE. NO. 1614 Pennington ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of J. Fredrick Raber

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Heilmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Schole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Minnie Raber 1614 Pennington ave

15 Feb 5 1923 Robt P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 3rd 1923 to Feb 3rd 1923

that I last saw h alive on Feb 3rd 1923

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

La Grippe

unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis

(Signed) Thos B. Horton M. D.

Feb 5 1923 (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Feb 6 1923
20 UNDERTAKER	ADDRESS
Margaret D. Flynn	14 N Eutaw St

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... shou... State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 5 - 1923

Spec.—1-10-21—M&T—1500 Bks. Grover C. Pelton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72052 D72052

X 117

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hosp ST., 11 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grover C. Pelton

(a) RESIDENCE NO. 1323 Eutaw Place ST., ... WARD Springfield Mass.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [redacted] Denise Pelton

6 DATE OF BIRTH (month, day, and year) May 29. 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Somers

(State or country) Conn.

PARENTS

10 NAME OF FATHER Jerome Pelton

11 BIRTHPLACE OF FATHER (city or town) Somers.

(State or country) Conn.

12 MAIDEN NAME OF MOTHER Mae Fisk

13 BIRTHPLACE OF MOTHER (city or town) Boston,

(State or country) Mass.

14 Informant (Address) Mrs. Stein. 1323 Eutaw Place.

15 Filed FEB 5 1923, 19 Robert F. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1923, to Feb 5, 1923,

that I last saw her alive on Feb 5, 1923,

and that death occurred, on the date stated above, at 11.35 A m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 2/2/23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Chas Wilbur Stein, M. D.

2/5. 1923 (Address) 1286. 2814 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Springfield Mass. DATE OF BURIAL 2/8/1923

20 UNDERTAKER Harry H Kittle ADDRESS 1631 Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Rotch 1623 E North Ave.

Spec.—1-10-21—M&T—1500 Bks.

D72053

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72053

100-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ger. N Cole Jr ST., 8 WARD)

2-FULL NAME 916 Elwood Place

(a) RESIDENCE NO. 916 Elwood Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 29 1922

7 AGE	Years	Months	Days	If LESS than 1 day..... hrs. or min.
	1	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) — 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo. N Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Blanche L. Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Geo. N. Cole (Address) 916 Elwood Place

15 Filed ..., 19 ... E. F. Harrison, Registrar

(Burial Permit Issued)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/4, 19 23, to 2/5, 19 23,

that I last saw h alive on 2/5, 19 23

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno. A Rustop, M. D.

, 19 (Address) 612 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Parkwood DATE OF BURIAL Feb 6 1923

20 UNDERTAKER Wm Cole ADDRESS 602 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shou state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC TION is very important. See instructions on back of certificates.

5-1923

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72054

CERTIFICATE OF DEATH.

D72054

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Madison Ave ST., 14 WARD)

2-FULL NAME Margaret Myers

(a) RESIDENCE NO. 1808 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13th 1849

7 AGE 74 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady at Home

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Penna

PARENTS

10 NAME OF FATHER Lawrence Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia Penna

12 MAIDEN NAME OF MOTHER Margaret Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Edward L. Myers

(Address) 1808 Madison Ave

15 Feb 5 1923, 19 Robert F. Morrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany, 1923, to Feb. 4th, 1923, that I last saw her alive on Feb 3rd, 1923, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia.

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic examination

(Signed) John Blatland, M. D.

Feb 5th, 1923 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 2-6 1923

20 UNDERTAKER: Henry H. Jenkins & Sons Co

ADDRESS: Orchard Mt. Holly N.J.

B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72055

D72055

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 205 Southway ST., Guilford WARD)

2-FULL NAME Charles Canby Garrett

(a) RESIDENCE NO. 205 Southway ST. Guilford WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If ~~married~~, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year) August 4th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Md

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Wilmington (State or country) Del

PARENTS

10 NAME OF FATHER Harry Garrett

11 BIRTHPLACE OF FATHER (city or town) Wilmington (State or country) Wilmington Del

12 MAIDEN NAME OF MOTHER Catherine Canby

13 BIRTHPLACE OF MOTHER (city or town) Wilmington (State or country) Del

14 Informant George Reuder (Address) 205 Southway Guilford

15 Filed FEB 5 1923 R. [illegible] Harrison, Registrar

By [illegible] Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from January 31st, 1923, to Feby 4th, 1923, that I last saw him alive on Feby 4th, 1923, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Dysentery (duration) 12 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

Feby 5, 1923 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bessyville Va

DATE OF BURIAL: Feb 5 1923

20 UNDERTAKER: H.W. Jenkins - Sons Co

ADDRESS: Orchard & Collok

N.B.—WRITE PLAINLY, WITH INK. ALL items should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72056

CERTIFICATE OF DEATH.

74-001 D72056

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1630 N. Durham St

CITY OF BALTIMORE: (No. 1630 N. Durham ST., 8 WARD)

2-FULL NAME George Prediger

(a) RESIDENCE No. 1630 N. Durham ST., 8 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widower

5a If married, widowed, or divorced HUSBAND) of (or) ~~WIFE of~~: Christena Prediger

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
59	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Freda Nelson (daughter)
(Address) 1630 N. Durham St

15 Filed ..... 19 ..... Registrar

FEB 5 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1923 to Jan. 3, 1923

that I last saw him alive on Jan 3, 1923

and that death occurred, on the date stated above, at 9-4 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos 18 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. C. Armacost, M. D.

(Address) 1540 N. Broadway Feb 4, 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Feb

DATE OF BURIAL: 6 1923

20 UNDERTAKER: Chas. M. Fink & Son

ADDRESS: 811 N. Wolfe St.

B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72057 31 D72057

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 N Belnord St. 17 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William T. DeHaven

(a) RESIDENCE NO. 813 N. Belnord Ave ST. .... WARD ....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE must be filled in mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Estelle DeHaven

6 DATE OF BIRTH (month, day, and year): March 27-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37.	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pipe fitter 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Edmund DeHaven

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wash. D.C.

12 MAIDEN NAME OF MOTHER: Ella Sloan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs E DeHaven
(Address): 813 N Belnord Ave

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 4, 1923, that I last saw h alive on Feb 4, 1923 and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs

(Signed) T. C. Harter M. D.

Feb 5, 1923 (Address) 1201 N Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Feb 7 1923

DATE OF BURIAL

20 UNDERTAKER: Geo W Fenby & Son 511 N Wolfe St

ADDRESS

Robert F. Harrison, Registrar

Feb 5 - 1923

Harold Ferrell Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72058

CERTIFICATE OF DEATH.

71-00 D72058

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO. .....

CITY OF BALTIMORE: (No. 7 ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Keefe

(a) RESIDENCE NO. 901 N. Castle ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Keefe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Baebl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Record (Address) Johns Hopkins Hospital

15 Filed ..., 19 ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1922, to February 4, 1923, that I last saw h[illegible] alive on February 4, 1923, and that death occurred, on the date stated above, at 6.55 p.m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus. Obstructive

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Spinal meningitis when 3 mos

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Dec. 1. 1922

Was there an autopsy? Partial (Head)

What test confirmed diagnosis? Operation

(Signed) F. H. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL Feb 8th 1923

20 UNDERTAKER Geo. H. Smith Son ADDRESS 5111 Wash

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE INFORMATION ... EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72059

99-001 D72059

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 N Bethel ST.: 8 WARD)

2-FULL NAME Katherine Schaerf

(a) RESIDENCE. NO. 1820 N Bethel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Schaerf

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Kamm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Katherine Kamm 1820 N Bethel St

15 Filed ....., 19.. Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923, to Feb 5, 1923, that I last saw h.. alive on Feb 5, 1923, and that death occurred, on the date stated above, at 8 00 m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo [illegible] M. D.

784 1923 (Address) 1107 Hunington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery DATE OF BURIAL: Feb 6 1923

20 UNDERTAKER: Geo Jno. Fink & Son ADDRESS 811 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS ... state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

FEB 5 - 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72060

D72060

CERTIFICATE OF DEATH.

REGISTERED NO. 100-00

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 3537 Everhart St., 13 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie V. Taylor

(a) RESIDENCE NO. 3537 Everhart St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 22-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles H. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie B. Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Charles H. Taylor (Address) 3537 Everhart St.

15 Filed Feb 6, 1923 Robert F. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1923, to Feb 5th, 1923, that I last saw h[illegible] alive on Feb 5th, 1923, and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical symptoms

(Signed) W. A. Fallin, M. D.

Feb 6, 1923 (Address) 1527 Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's (Hampden) DATE OF BURIAL Feb. 6 1923

20 UNDERTAKER Horace H. Burgee ADDRESS 363 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCU- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

26 - 1923

Spec.—8-24-14—M. & T.—2000 Bks.

Barbara Matejka

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72061

CERTIFICATE OF DEATH.

90 D72061

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 N. Chapel ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Matejka

(Residence in Baltimore: No. 507 N. Chapel St.; 53 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, ... January ....., (Month) 1 (Day) ..... (Year)

7-AGE, 77 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Ben

(Address) 507 N. Chapel St.

15-FEB 6 - 1923 ROBERT R. KRAUTER,
Filed....., 191..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 4, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1923, to Feb 4 1923, that I saw h[illegible] alive on Feb 3 1923, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 2 yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) A with Cardiac Dilatation

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) 77 Burned M. D.

2-5-23, 191.. (Address) 507 N. Chapel St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Feb ....., 191..
20-UNDERTAKER	ADDRESS
[illegible] Sons	[illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72062

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D72062

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Beach St., Curtis Bay ST., 23 WARD)

2-FULL NAME Antonia Cecelia Rosar

(a) RESIDENCE NO. 4 Beach St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE INFORMATION ASKED FOR MUST BE GIVEN EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. See instructions on back of certificates. It is very important.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Sept. 26th 1922

7 AGE — Years: — Months: 4 — Days: 9 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): X

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Curtis Bay Md

PARENTS

10 NAME OF FATHER: Frank Rosar

11 BIRTHPLACE OF FATHER (city or town) (State or country): Curtis Bay Md

12 MAIDEN NAME OF MOTHER: Julia Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Frank Rosar

(Address): 4 Beach St.

15 Filed FEB 6 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1923. to Feb. 4, 1923.

that I last saw her alive on Feb. 4, 1923.

and that death occurred, on the date stated above, at 9:50 p. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchpneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) Jos. [illegible], M. D.

2/4, 1923 (Address) 41 Church St. Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross — DATE OF BURIAL: Feb 6 1923

20 UNDERTAKER: [illegible] — ADDRESS: [illegible]

D72063

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D72063

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 922 W. Fayette St. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Thomas W. Mackey

(Residence in Baltimore: No. 922 W Fayette St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widow(er), or Divorced. (Write the word.) Single

6-DATE OF BIRTH. Sept. (Month) 12 (Day) 1863 (Year)

7-AGE. 59 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Stable Keeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Patrick Mackey

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Kathrin Burgess

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Coleman

(Address) 2142 Walbrook Ave

15- Filed FEB 6 - 1923 192.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 5 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart

(Duration) Don't Know mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) H. K. Gorsuch M. D. (Coroner.)

2-6-1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. St Peters Cem

DATE OF BURIAL. 2/7 1923

20-UNDERTAKER. J J Conan & Son

ADDRESS 901 Hollins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If LESS than 1 day state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72064

CERTIFICATE OF DEATH.

38 D72064

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 S. Sharp ST., 22 WARD)

2-FULL NAME Jeremiah Baptiste

(a) RESIDENCE NO. 806 S. Sharp ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? 12 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Baptiste

6 DATE OF BIRTH (month, day, and year) Oct, 11, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	45	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer) Storing Lumber

(c) Name of employer Baltimore Cooperage

9 BIRTHPLACE (city or town) Nevis
(State or country) West Indies

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) ..
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) ....
(State or country) unknown

14 Informant Mollie Baptiste
(Address) 806 S. Sharp

15 FEB 6 - 1923 ROBERT R. KRAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct, 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1922, to Oct, 3, 1923.
that I last saw him alive on Oct, 2, 1923,
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:

Aneurysm of Aorta

Known (duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Syphilis (duration) unknown mos. ds.

18 Where was disease contracted if not at place of death? -
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? X ray - Hospitals -
(Signed) Dave Trowbridge, M. D.
2/5, 1923 (Address) 1210 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Feb 7 1923

20 UNDERTAKER Jno H. Toadvine — ADDRESS 1212 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. The information required must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72065

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72065

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. FOREST AVE. 1ST HOUSE WEST OF RIDGE AVE. ST., 1 WARD) OVERLEA

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ROBERT W. A. JOHANNS.

(a) RESIDENCE NO. FOREST AVE. 1ST HOUSE WEST OF RIDGE AVE. ST., WARD OVERLEA.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	MARRIED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of THERESA JOHANNS.

6 DATE OF BIRTH (month, day, and year) MARCH 8th, 1888.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work MERCHANT

(b) General nature of industry, business, or establishment in which employed (or employer) POULTRY

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) GERMANY.

PARENTS

10 NAME OF FATHER CARL JOHANNS

11 BIRTHPLACE OF FATHER (city or town) (State or country) GERMANY

12 MAIDEN NAME OF MOTHER UNKNOWN

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant THERESA JOHANNS.
(Address) OVERLEA, MARYLAND.

15 Filed FEB 6 - 1923, 19 Registrar

BURIAL Permit Clerk

ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB. 3rd, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1923, to Feb. 3, 1923, that I last saw him alive on Feb. 3, 1923, and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

2/4, 1923 (Address) Rosedale, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pattenson Cemetery	Feb 6, 23
UNDERTAKER	ADDRESS
Fred Lenhart	Loma Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL DOCUMENT. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72066 HEALTH DEPARTMENT—CITY OF BALTIMORE D72066

CERTIFICATE OF DEATH.

29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Lambdin

(a) RESIDENCE NO. Kenilworth & Beaumont Aves. (Board) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William S. Lambdin

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: 32 Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: John Glauber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland.

12 MAIDEN NAME OF MOTHER: Louisa Meyer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland.

14 Informant: Wm S. Lambdin

(Address): Kenilworth & Beaumont Aves.

15 Filed: FEB 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1923, to Feb. 4, 1923, that I last saw her alive on Feb. 4, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Chr. Nephritis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Delivery Date of Feb. 2, 1923

Was there an autopsy? No (Child Birth)

What test confirmed diagnosis? Sub & Clinical findings

(Signed) George E. Shannon M. D.

2/4, 1923 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Feb 7 19

20 UNDERTAKER: E. Sellmann & Son ADDRESS: Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

D72067

D72067

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 16 E Randall St. 12 (WARD)

2-FULL NAME Katherine L. Eberlein

(a) RESIDENCE. No. 16 E. Randall ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Conrad Eberlein

6 DATE OF BIRTH (month, day, and year): June 24th 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germy

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germy

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germy

14 Informant: Frederick W. Eberlein

(Address): 16 E. Randall St.

15 Filed FEB 6-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1923, (to Feb 4, 1923. that I last saw her alive on Feb 3, 1923. and (that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

1 Bronchitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. [illegible], M. D.

2-6, 1923 (Address) 16 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sudbrook Park	Feb 7th 1923
20 UNDERTAKER: E. Schlosman & Son	ADDRESS 103 Hanover St

Sec. 6. Burial permit should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–1-10-21–M&T–1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72068

CERTIFICATE OF DEATH.

D72068

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Peach Alley ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joans Perkins

(a) RESIDENCE NO. 1124 Peach Alley ST., WARD Alabama

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred – yrs. 4 mos. – ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May, 22, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	17	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Consolidated Gas Elec Co

9 BIRTHPLACE (city or town) Russell Co. (State or country) Alabama

PARENTS

10 NAME OF FATHER Isaiah Coleman

11 BIRTHPLACE OF FATHER (city or town) Russell Co (State or country) Alabama

12 MAIDEN NAME OF MOTHER Willie Moses

13 BIRTHPLACE OF MOTHER (city or town) Russell Co (State or country) Alabama

14 Informant Willie Perkins

(Address) 1124 Peach Alley

15 Filed FEB 6 – 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb, 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan, 3, 1923, to Feb, 5, 1923, that I last saw him alive on Feb, 4, 1923, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ..

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Davis Franklin, M. D.

2/5, 1923 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn ct. DATE OF BURIAL Feb 7 1923

20 UNDERTAKER V. G. Brown and Son ADDRESS 1080 W Fayette

N. B. WRITE plainly with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72069

REGISTERED No. C

1-PLACE OF DEATH Gray M. E. Church

CITY OF BALTIMORE (No. Cor. Laurel & Carrollton Av. St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rev. Albert A. Bichell

(Residence in Baltimore: No. 813 N. Gilmor St. St.; yrs. 57 mos. 10 ds. 25)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, March 10, 1865
(Month) (Day) (Year)

7-AGE, 57 yrs. 10 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Minister
(b) General nature of industry, business, or establishment in which employed (or employer). (Retired)

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. A. Bichell

(Address) 813 N. Gilmor St.

15-
Filed FEB 6 - 1923, 191... ROBERT B. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 4, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ...yrs....mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ...yrs....mos....ds.

(Signed) T. J. Hennessy, M. D.
(Coroner.)

Feb 5, 1923 (Address) 2350 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, Feb. 7, 1923

20-UNDERTAKER Jos. Joerdens Son — ADDRESS 217 S. Pine

D72070

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 74-001 D72070

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 610 W. Balto St. St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Blumenthal

(Residence in Baltimore: No. 610 W Balto St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Sgle

6-DATE OF BIRTH, Dec (Month) 5 (Day) 1865 (Year)

7-AGE. 57 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balt City

PARENTS.

10-NAME OF FATHER. B. Blumenthal

11-BIRTHPLACE OF FATHER, (State or Country). B. City

12-MAIDEN NAME OF MOTHER. Fanny Stern

13-BIRTHPLACE OF MOTHER. (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed. Blumenthal

(Address) Entaw Place Pimlico

15- FEB 6 - 1923 Filed ..... 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1/26 (Month) 5 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy~~ or inquiry.) thereon and from the evidence obtained by said ..... ~~(Inquest, au~~ ..... ~~topsy~~ or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy a few hrs

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Foncek M. D. (Coroner.)

2-6 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Ohr Shalom Cem.	2/7/ 1923
20-UNDERTAKER.	ADDRESS
David Sondheim	116 W. Mt. Royal Ave

N. B.—Every item of information should be carefully supplied. Absolutely state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72071

CERTIFICATE OF DEATH.

31

D72071

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 3 WARD)

2-FULL NAME Mason Johnson

(a) RESIDENCE NO. 1433 Boundary Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city town and State)

N.B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Johnson

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lavinia Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M. T. H.

15 Filed FEB 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1922 to Feb. 2, 1923.

that I last saw him alive on Feb. 2, 1923

and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 ? yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? B. Tb. in sputum, X-ray

(Signed) Francis L. Padeglia M. D.

2-2-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harmonia Cem Washington Loc	Feb 6 1923

20 UNDERTAKER Burr Robert A Elliott Parkland ADDRESS 1725 Pa

D72072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72072
Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 617 N. Dallas St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Wm H. Moore

(Residence in Baltimore: No. 617 N. Dallas St.; yrs. 45 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced. (Write the word.) M

6-DATE OF BIRTH. Feb 1 1878 1923
(Month) (Day) (Year)

7-AGE. 45 yrs. ..... mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Ship Caulker

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Wm H Moore

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriet Moore

(Address) 617 N. Dallas

15-Filed FEB 6 - 1923 192.... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 2 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Vatter M. D.
(Coroner)

2-3 192.. (Address) 508 E. Monument Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem. DATE OF BURIAL. Feb 6 1923

20-UNDERTAKER. Wm Robert Gilmerland Jr ADDRESS 1725

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72073

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D72073

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Christ's Institution Hospital ST., 10 WARD)

2-FULL NAME Susan Johnson

(a) RESIDENCE NO. 704 Ensor St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Eutaw mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 71 Years — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Homework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Dr. Renard (Address) 708 Ensor St.

15 Filed FEB 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22 - 1923. to February 4. 1923. that I last saw her alive on February 4. 1923. and that death occurred, on the date stated above, at 5.30 A.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Bright Disease & Broncho Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Bright Disease Broncho Pneumonia (duration) yrs. 4 mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr. R. W. Kennard M. D.

2-4. 1923 Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Feb 7 1923

20 UNDERTAKER Mrs Robert J. Elliott — ADDRESS 1725 Oakland

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72074

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72074

CERTIFICATE OF DEATH.

18 179

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Franklin Square Hospital 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Leroy Wahl

(Residence in Baltimore: No. 1078 Carlton St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	Single

6-DATE OF BIRTH. March (Month) 24 (Day) 1918 (Year)

7-AGE. 4 yrs. 10 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Alexander Wahl

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Margaret Dorsey

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Wahl

(Address) 1078 Carlton St

Filed FEB 6 - 1923, 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 4 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Em death on the day stated above.

The CAUSE OF DEATH* was as follows:

3° Burns of head face & side, body & adjacent parts, clothing pulled off by fire. (Duration) hours. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Fenton M. D. (Coroner.)

Feb 5 1923 (Address) 730 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death 1 mo 20 ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 1078 Carlton St

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Olivet	Feb 6, 1923

20-UNDERTAKER.	ADDRESS
John J Fields	1200 W Fayette St

N. B.—Every item of information should be carefully supplied. All should be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72075

CERTIFICATE OF DEATH.

90 D72075

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 Homewood St. 9 WARD)

2-FULL NAME Agnes Coppinger

(a) RESIDENCE NO. 1317 Homewood as. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Coppinger Dec'd

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years 40 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Houses

(b) General nature of industry, business, or establishment in which employed (or employer): Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Brogan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mary Brogan 1317 Homewood

15 Filed FEB 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1922, to Feb 5, 1923, that I last saw h[illegible] alive on Feb 5, 1923, and that death occurred, on the date stated above, at 12.50 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation 14 days (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Jno. F. Geraghty M. D.

19 (Address) 2036 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: Feb 8 1923

20 UNDERTAKER: M. C. Widdefield 914

ADDRESS: Greenmt

Spec.—1-10-21—M&T—1500 Bks.

D72076

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72076

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1123 Gorsuch Ave ST., 9 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. S. Bell

(a) RESIDENCE NO. 1123 Gorsuch Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8 1922

7 AGE — Years: — Months: 5 Days: 27 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Harry M Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER Mary C Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Mary C. Bell 1123 Gorsuch Ave

15 Filed . 19 Dr Jno Fenby Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 . 1923 . to Feb 4 1923.

that I last saw him alive on Feb 4 . 1923.

and that death occurred, on the date stated above, at 9- P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Asylum of Deaths

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John L Fenby, M. D.

2/5, 1923 (Address) 3922 Greenmount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park | DATE OF BURIAL: Feb 6 1923

20 UNDERTAKER: H. C. Middlecoat | ADDRESS: 914 Greenmount

N. B.—Answers to questions must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C D72077

D72077

CITY OF BALTIMORE: (No. 1324 Druid Hill Ave ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A Braxston

(Residence in Baltimore: No. 1324 Druid Hill Ave St.; 40 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be GIVEN EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. ..... (Month) Unknown (Day) ..... (Year)

7-AGE. 51 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). None

9-BIRTHPLACE, (State or Country). Frederick Co Md

PARENTS.

10-NAME OF FATHER. Sebastian Hammond

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Mercella Franklin

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar H Braxton

(Address) 1324 Druid Hill Ave

FEB 6 - 1923

Filed ..... 191 ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 3, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1923, to Feb 3 1923, that I saw h Er alive on Feb 3 1923, and that death occurred, on the date stated above, at 10:25 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Chronic Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. 8 ds.

(Signed) H S McCard M. D.

2/6, 1923 (Address) 2005 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Auburn

DATE OF BURIAL, 2/6, 1923

20-UNDERTAKER, Samuel T Hamerberg

ADDRESS Middle

D72078 HEALTH DEPARTMENT—CITY OF BALTIMORE D72078

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1536 McCulloh ST. 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary R. Jackson

(Residence in Baltimore: No. 1536 McCulloh St.; 57 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): married

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1872 (Year)

7-AGE: 51 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Jackson

(Address) 1536 McCulloh St.

15-

Filed ..... 1923. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: ..... Feb. 2, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... history

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. J. Hennessy M. D.
(Coroner.)

Feb. 5, 1923 (Address) 502 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn

DATE OF BURIAL: Feb. 6, 1923

20-UNDERTAKER: Samuel Hensley

ADDRESS 578 Mt. Auburn

D72079

HEALTH DEPARTMENT—CITY OF BALTIMORE D72079

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 129

CITY OF BALTIMORE (No. 256 So. Bethel ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hardy

(Residence in Baltimore: No. 256 So Bethel St St.: 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Unknown ....., 1..... (Month) (Day) (Year)

7-AGE: about 5 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 37

9-BIRTHPLACE, (State or Country): Va

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Bundy

(Address) 1525 E. Fayette

15- Filed FEB 6 - 1923, 191.....

ROBERT E. LAWLOR Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 2nd, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Bright's Disease
Unknown
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Signed Thos. B. Horton M. D.
(Coroner)
Feb 5 1923 (Address) Curtis Bay, Md

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Laurel Cemetery

DATE OF BURIAL, Feb 5, 1923

20-UNDERTAKER: Robert Pearham

ADDRESS 220 N. Hamburg St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

76 D72080
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 William St.: 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Conway

(a) RESIDENCE. No. 1507 William St., 2nd WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Mrs Lou Conway

6 DATE OF BIRTH (month, day, and year) 10.26.1850

7 AGE 72 Years 3 Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER John Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER Celestine LaBarra

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs L Conway
(Address) 1507 William st

15 Filed FEB 6 - 1923 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2.3. 1923

17 I HEREBY CERTIFY, That I attended deceased from 1.26, 1923, to 2.3, 1923, that I last saw h[illegible] alive on 2.3, 1923, and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

about 9 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. J. Burlington, M. D.

2-3 1923 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	2/6/1923
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son - 1460	Battery Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72081 D72081

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1846 Oliver ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac N. Mayhorne

(a) RESIDENCE NO. 824 E. Pleasant ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N.B.—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	81	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Ben Mayhorne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Brady (Address) 1824 E Pleasant St

FEB 6 - 1923

Filed ROBERT B. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1923, to Feb 4, 1923, that I last saw him alive on Feb 4, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation + Pulmonary Edema

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Aortic Stenosis or Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms + Signs

(Signed) David Miller, M. D.

, 19 (Address) 1506 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL 2/11 1923

20 UNDERTAKER E. J. Fleming & Son — ADDRESS 1438 W. Lafayette Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72082

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72082

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1431 Myrtle Ave ST.: 14 WARD) 11-00

2-FULL NAME Preston Lewis

(a) RESIDENCE. No. 1431 Myrtle Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. Lifetime ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31 93

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Harrow Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mollie Dalton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

11 Informant Lou Ruth (Address) 1431 Myrtle Ave

15 Filed FEB 6 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 — 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 4 — 1923 to Feb 5th — 1923 that I last saw him alive on Feb 5 — 1923 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

about — (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) History La Grippe

about (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Relro

Did an operation precede death? Date of no

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) Samuel A Bain M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft - Auburn DATE OF BURIAL Feb 7 1923

20 UNDERTAKER Wm. H. Case & Son ADDRESS Woodlawn

INSTRUCTIONS: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72083 HEALTH DEPARTMENT—CITY OF BALTIMORE D72083

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 19 WARD)

2-FULL NAME Charles R. Daily.

(a) RESIDENCE NO. 916 Pierce St. City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Clara Daily (wife)

6 DATE OF BIRTH (month, day, and year) March 19, 1858.

7 AGE: Years 69 Months 10 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Richard Daily

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER Delia Hill.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Federals (Address)

15 Filed FEB 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1923, to Feb. 4, 1923, that I last saw him alive on Feb. 4, 1923, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ~~one~~ yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R Bagg, M. D.

2-5, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Feb 8 1923

20 UNDERTAKER: Wm. H. Chase & Son — ADDRESS: 1400 Mosher

N. B.—WRITE PLAINLY with indelible pencil. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72084

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

57 D72084

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 3024 Annah Ave ST.: 16 WARD)

2-FULL NAME Phillip Louis Brady.

(a) RESIDENCE. No. 3024 Annah Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa F. Brady.

6 DATE OF BIRTH (month, day, and year): Oct 16 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): Button Mfg. Co.

(c) Name of employer: Alma Mfg. Co.

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Conrod F. Brody.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs. George C. Bertz.
(Address): 3024 Annah Ave

15 Filed FEB 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 3 1923

17 I HEREBY CERTIFY, That I attended deceased from March, 1922, to Feb 3rd, 1923, that I last saw him alive on Feb 2, 1923, and that death occurred, on the date stated above, at 8.30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

Diabetes (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of amputation of Leg About Nov 1922

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm Michel, M. D.

Feb 4. 1923 (Address) 2901 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: Feb 6 1923

20 UNDERTAKER: George C. Schnabel

ADDRESS: 2101 Eutaw Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72084

CERTIFICATE OF DEATH.

57 D72084

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3024 Annah Ave ST.: 16 WARD)

2-FULL NAME Phillip Louis Brady.

(a) RESIDENCE. No. 3024 Annah Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa F. Brady.

6 DATE OF BIRTH (month, day, and year) Oct 16 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) Button Mfg. Co.

(c) Name of employer Alma Mfg. Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Conrod F. Brady.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. George C. Berk.
(Address) 3024 Annah Ave

15 FEB 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1923

17 I HEREBY CERTIFY, That I attended deceased from March, 1922, to Feb 3rd, 1923, that I last saw him alive on Feb 2 1923 and that death occurred, on the date stated above, at 8.30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

Diabetes (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of Amputation of Leg About Nov 1922

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm Ruchel, M. D.

Feb 4, 1923 Address) 2901 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 6 1923

20 UNDERTAKER George C. Schwab ADDRESS 210 Eutaw St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. Age should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72085 ✓ 40 D72085

D72085

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 918 Hanover St. St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest F.W.Rehmert. 35. --- 5 --- 27.

(Residence in Baltimore: No. 918 Hanover Street. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. August 8, 1887. (Month) (Day) 1..... (Year)

7-AGE. 35 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Broom-maker.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles R.Rehmert.

11-BIRTHPLACE OF FATHER, (State or Country). Germany.

12-MAIDEN NAME OF MOTHER, Caroline T.Wise.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles C.Rehmert.(brother).

(Address) 918 Hanover Street.

15- FEB 6 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 4th, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D. (Coroner.)

Feb. 4th, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Balto Cemetery. DATE OF BURIAL. Feb 7 1923

20-UNDERTAKER. George L. Schwab ADDRESS 701 Fulton Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72086

D72086

CERTIFICATE OF DEATH.

21

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 Euclid Ave ST. 27 WARD)

2-FULL NAME William Corey

(a) RESIDENCE NO. 633 Euclid Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ W. Irene Corey

6 DATE OF BIRTH (month, day, and year) Nov 3-1847

7 AGE — Years: 75 | Months: 3 | Days: 2 | If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: William Corey

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Martha Scoggins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mrs W Irene Corey
(Address) 633 Euclid Ave

15 Filed FEB 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 31st 1923, to Feb. 4th 1923, that I last saw h iw alive on Feb. 4th 1923, and that death occurred, on the date stated above, at 11.30P m.

The CAUSE OF DEATH* was as follows:

Erysipelas (Facial)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) George E Cross, M. D.

, 19 (Address) 2409 Md. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Stanfield — DATE OF BURIAL: Feb 7 1923

20 UNDERTAKER: A S Marshall 3539 — ADDRESS: Feb 14

Note—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72087

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161 D72087

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1416 N. Bond Way ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Smith

(Residence in Baltimore: No. 1416 N. B. Way St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, May (Month) 30 (Day) 1870 (Year)

7-AGE, 52 yrs. 8 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Letter Carrier
(b) General nature of industry, business, or establishment in which employed (or employer): U.S. Government

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, James H. Smith

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Mary Jones

13-BIRTHPLACE OF MOTHER (State or Country), Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ida B Smith

(Address) 1416 N B Way

15- FEB 6-1923 ROBERT R. KRAUTER,

Filed....., 191... Burial Permit Clerk..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 5 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Syncope - Illuminating Gas asphixiation

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration)...2...yrs.....mos.....ds.

(Signed)..... (Coroner.) M. D.

2-6-1923 (Address) 508 E Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Balto Cemetery

DATE OF BURIAL, Feb 5, 1923

20-UNDERTAKER A S Marshall

ADDRESS 933 Fulton Ave

N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72088

D72088

CERTIFICATE OF DEATH.

57

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., ... WARD)

2-FULL NAME Dorothea Grasmick

(a) RESIDENCE NO. Unknown ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	69	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Philip Loftus

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Europe

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Municipal Hospital Records.
(Address)

15 Filed FEB 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 19 23

17 I HEREBY CERTIFY, That I attended deceased from January 25, 19 23, to February 3, 19 23, that I last saw her alive on February 2, 19 23, and that death occurred, on the date stated above, at 1:30 A.M. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Do Do

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clin

(Signed) Clyde Mitchell, M. D.

2/3/ 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	2/6 19 23
20 UNDERTAKER J. J. Moran	ADDRESS 300 E Balto St.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72089

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

94-001 D72089

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Forest Road Roland Park ST., 27 WARD)

2-FULL NAME Sophia Wardley Jenkins

(a) RESIDENCE. No. 503 Forest Road Roland Park ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Adam Hubley Jenkins

6 DATE OF BIRTH (month, day, and year) May 15 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Greenville
(State or country) South Carolina

PARENTS

10 NAME OF FATHER Charles W. D'Oyley

11 BIRTHPLACE OF FATHER (city or town) Charleston
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Sarah Ann Baker

13 BIRTHPLACE OF MOTHER (city or town) Charleston
(State or country) South Carolina

11 Informant Samuel K. Jenkins
(Address) 503 Forest Road Roland Park Md

12 FEB 6 - 1923 ROBERT R. KRAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2 1923 to Feb. 5 1923, that I last saw h— alive on Feb. 5 1923, and that death occurred, on the date stated above, at 8:55 P. m.

The CAUSE OF DEATH* was as follows:

Acute pulmonary edema

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Senile arteriosclerosis, Arterial hemorrhage (duration) 5 yrs. 7 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Gibson Parlin, M. D.

2/6, 1923 (Address) 722 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenville S. Co. DATE OF BURIAL 2/6/23

20 UNDERTAKER A E Hughes ADDRESS 424 N. Bdway

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72090

CERTIFICATE OF DEATH.

74-001

D72090

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 Roland Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanne Weber

(a) RESIDENCE NO. 34 Roland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Frederick W. Weber

6 DATE OF BIRTH (month, day, and year) May 2-34

7 AGE: Years 88 Months 9 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant Lula Gunther

(Address) 34 Roland Ave

15 FEB 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/4 1923

17 I HEREBY CERTIFY, That I attended deceased from March, 1922, to February 4, 1923, that I last saw her alive on February 4, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Apoplexia

(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? ? Date of ?

Was there an autopsy? ?

What test confirmed diagnosis? ?

(Signed) A. H. A. Mayer, M. D.

, 19 (Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine

DATE OF BURIAL 2/7 1923

20 UNDERTAKER Philip Henry

ADDRESS 2011 Orleans

Wallie Clayton Body sent to morgue to be burried by the city

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72091

CERTIFICATE OF DEATH.

90 D72091

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 709 W Balto St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wallie Clayton

(Residence in Baltimore: No. 709 W Balto St. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widow(er) or Divorced. (Write the word.) Widow

6-DATE OF BIRTH. Dont Know (Month) (Day) (Year)

7-AGE. 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Worker
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Dont Know

PARENTS

10-NAME OF FATHER. ( )

11-BIRTHPLACE OF FATHER, (State or Country). ( )

12-MAIDEN NAME OF MOTHER. ( )

13-BIRTHPLACE OF MOTHER, (State or Country). ( )

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Clayton

(Address) 709 W Balto St

15- Filed FEB 6 - 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 2 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

Dont Know (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(Duration) yrs. mos. ds.

(Signed) H K Formwalt M. D. (Coroner.)

2-6 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. W Lawn Cem. DATE OF BURIAL. 2/7/23

20-UNDERTAKER. J J Crane Jr. ADDRESS 501 Aisquith

N. B.—Every item of information should be given as accurately as possible. Be sure to properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72092

D72092

CERTIFICATE OF DEATH.

REGISTERED NO. C 8 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1761 N. Gay ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha L. Haas

(Residence in Baltimore: No. 1761 N. Gay St.; ..... yrs., 3 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov. (Month) 19 (Day), 1922 (Year)

7-AGE, ... yrs. 2 mos. 16 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Wm F. Haas

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Pearl Herrington

13-BIRTHPLACE OF MOTHER (State or Country). W Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm F. Haas

(Address) 1761 N Gay St

15- Filed FEB 6 - 1923, 191... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 5 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 25 1923, to Feb 5 1923, that I saw h[illegible] alive on Feb 5 1923, and that death occurred, on the date stated above, at 9H m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Henry A Weinberg M. D.

Feb 5, 1923 (Address) 7240 Lafayette Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Country — DATE OF BURIAL, Feb 6..., 1923

20-UNDERTAKER A M Routson — ADDRESS 2230 N Gay St

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72093

CERTIFICATE OF DEATH.

90 D72093

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 509 Orkney Rd ST.; 27 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank S Lewis

(Residence in Baltimore: No. 509 Orkney Rd St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, Oct (Month) 29 (Day), 1852 (Year)

7-AGE, 70 yrs. 3 mos. 7 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dentist
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph H. Lewis.

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Hannah Spencer

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. D. Lewis Jr

(Address) 509 Orkney Road

15- Filed FEB 6 - 1923, 191..... ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 5 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1922, to Feb 5 1923, that I saw h[illegible] alive on Feb 5 1923, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) 2 hours yrs. ..... mos. ..... ds.

(Signed) Geo H McKinney M. D.

Feb 5, 1923 (Address) 5535 York Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Fallston Md

DATE OF BURIAL, Feb. 7., 1923

20-UNDERTAKER W M Rouston

ADDRESS 2238 N Monroe

N. B.—Every item of information should be given so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72094

CERTIFICATE OF DEATH.

11-001 D72094

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 678 W Fayette ST.: 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Amelia Graham.

(a) RESIDENCE. No. 678 W. Fayette ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-29 22.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Shaw Graham

11 BIRTHPLACE OF FATHER (city or town) Camden
(State or country) N. J.

12 MAIDEN NAME OF MOTHER Marie Maier

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Andrew Shaw Graham.
(Address) 678 W Fayette St

15 6-1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-5 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-27, 1923, to 2-5, 1923, that I last saw her alive on 2-4, 1923, and that death occurred, on the date stated above, at 6:55 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? auscultation

(Signed) Chester Piland, M. D.

2-5, 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Feb. 7. 1923
20 UNDERTAKER Chas W. Dill	ADDRESS 3109 Fredk. Ave.

mation should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72095 . **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ D72095

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 S Fulton Ave ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John George Wittmann

(a) RESIDENCE NO. 1278 Fulton Ave ST., W WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Wittmann

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17 8	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Wittmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kunigunde

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine Wittmann (Address) 1278 Fulton Ave

15 Filed 6-1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 6 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to February 6 1923.

that I last saw h[illegible] alive on February 5, 1923.

and that death occurred, on the date stated above, at 12.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Henry J Hahn, M. D.

2/6, 1923 (Address) 3 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL Feb 9 1923

20 UNDERTAKER Chas W. Dill ADDRESS 3109 Fredk Ave.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

6-1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72096 11-001 D72096

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 r Massachusetts Ave ST. 20 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Lynwood Colvin

(a) RESIDENCE NO. 400 r Massachusetts Ave ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	W.	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of Nellie G. Colvin

6 DATE OF BIRTH (month, day, and year) Nov. 15, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42		2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General Elec Co

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James M Colvin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliza J Lilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Nellie G. Colvin
(Address) 400 r Massa Ave

15 Filed ..... 19 Robert P. Harrison, Registrar

B 6 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 22, 1923 to Feb 4, 1923

that I last saw h~~im~~ alive on Feb 3, 1923

and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) ..... yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Pneumonia Broncho

(duration) ..... yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. T. Hanna, M. D.

, 19 (Address) 1822 W Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Warrenton Cem: Va — DATE OF BURIAL Feb. 8. 1923

20 UNDERTAKER Chas W. Dill. — ADDRESS 3109 Fredk. Ave.

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72097

CERTIFICATE OF DEATH.

X101

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore Gen'l Hosp ST., 24 WARD)

2-FULL NAME Geraldine Lind

(a) RESIDENCE NO. Lanthicums Heights ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

PARENTS

10 NAME OF FATHER Fred Lind

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Fred Lind

(Address) Anderson Heights Md.

15 Filed ..... 1923 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 6 1923

17 I HEREBY CERTIFY, That I attended deceased from February 3 1923 to February 6 1923,

that I last saw h.. alive on February 6 1923,

and that death occurred, on the date stated above, at 11 80 m.

The CAUSE OF DEATH* was as follows: 1

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John A. O'Connor, M. D.

, 19 (Address) South Baltimore Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Feb 1923
20 UNDERTAKER	ADDRESS
A. Lunder & Sons	1210 Park

B 6 - 1923

G. B. WHITE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72098 ✓ 31 D72098

CERTIFICATE OF DEATH.

D72098

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 W Saratoga St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Oliver

(a) RESIDENCE. NO. 1143 W Saratoga ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Oliver

6 DATE OF BIRTH (month, day, and year) March 3, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Md

14 Informant Mary Oliver (Address) 1143 W Saratoga

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1923

17 I HEREBY CERTIFY, That I attended deceased from January, 1923, to Feb 3, 1923, that I last saw h alive on Feb 3, 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Organic Dis Heart

Pulm Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Abscess (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J J Moorewood, M. D.

Feb 7, 1923 (Address) 1334 Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Feb. 7, 1923

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 1114 W. Saratoga St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

6-1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72099 D72099

CERTIFICATE OF DEATH.

REGISTERED NO. 51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 S. Wolfe St. ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Zionek

(a) RESIDENCE NO. 734 S. Wolfe St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 26-1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attended.

(b) General nature of industry, business, or establishment in which employed (or employer) Parochial School

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Lawrence Zionek

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine Krasiak

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ger.

14 Informant Lawrence Zionek (Father)
(Address) 734 S. Wolfe St.

15 FEB 6-1923 .19 ..... Registrar

Robert F. Hartman
Asst Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1922, to Febr 7, 1923.

that I last saw her alive on Febr 7, 1923,

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis
Myocarditis - Chronic

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Nathan Hellegott, M. D.

, 19 (Address) 175 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem

DATE OF BURIAL Feb 7 1923

20 UNDERTAKER Lilly and Zeiler

ADDRESS 403 S. Wolfe

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72100 D72100

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 S. East Ave ST. 26 WARD)

2-FULL NAME Henry Hartman

(a) RESIDENCE NO. 527 S. East ave ST. 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Josephine Hartman

6 DATE OF BIRTH (month, day, and year) Nov. 28th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buyer for the

(b) General nature of industry, business, or establishment in which employed (or employer) Firm of Hemingway

(c) Name of employer Packing Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Zinkand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Paul Hartman (son) 527 S. East ave.

15 Filed ..... 19.. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to Feb 4, 1923

that I last saw her alive on ....., 19..

and that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broken Contractures

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Gross Clinton & Bacteriological

(Signed) Jno Clinton M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Feb 7th 1923

20 UNDERTAKER Lilly & Zeiler — ADDRESS 403 S. Wash

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Information as to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

6-1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72101

CERTIFICATE OF DEATH.

D72101

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 248 S. Elenton. ST. 26 WARD)

2-FULL NAME Rosalie Krug.

(a) RESIDENCE NO. 248 S. Elenton. ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of the late Friedrich Krug

6 DATE OF BIRTH (month, day, and year) Aug. 13th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Philipp Mauch.

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Joseph Rotti. (son)
(Address) 435 S. Robinson St

15 Filed 1-26-1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1923, to Feb 4, 1923, that I last saw h[illegible] alive on Feb 3, 1923, and that death occurred, on the date stated above, at 12 45 p. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage, Cerebral
Pulm Oedema
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Prostat. Colitis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Ladd, M. D.

Feb 5, 1923 (Address) 3323 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. A. A. C. DATE OF BURIAL: Feb 7 1923

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 4038 Wolfe St

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to report promptly. Information should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATTENDING PHYSICIAN'S CERTIFICATE is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72102/1

CERTIFICATE OF DEATH.

STILL BIRTH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 848 S. Sharp ST.: W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Harris

(a) RESIDENCE. NO. 848 S. Sharp ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 4, 1923

7 AGE: Years ... Months ... Days ... If LESS than 1 day, ... hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Turner

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Virginia

12 MAIDEN NAME OF MOTHER Rosella Mitchell Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Mother
(Address) UNIVERSITY OF MARYLAND.

15 Filed ... 19 FEB 6 - 1923

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1923 to Feb 4, 1923

that I last saw h/m alive on Feb 4, 1923,

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Abortion
(7 8 Mos)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) L. Norwood Wilson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ... DATE OF BURIAL ... 19

20 UNDERTAKER Commissioner Health. ADDRESS

Per Wm. B. WOODALL FEB 5 - 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72103

D72103

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1608 Patapsco St. ST. 23 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tony Rightmyer

(a) RESIDENCE No. 1608 Patapsco St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Rightmyer

6 DATE OF BIRTH (month, day, and year) Sept. 6 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	40	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Holland

PARENTS

10 NAME OF FATHER Henry Rightmyer

11 BIRTHPLACE OF FATHER (city or town) Holland (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs. Margaret Rightmyer
(Address) 1608 Patapsco St.

15 Robert F. Harrison, 19 Registrar
Burial Permit Clerk.

FEB 6-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Feb 5, 1923, that I last saw h.. alive on Feb 4, 1923, and that death occurred, on the date stated above, at 2.30A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinite
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H. F. Campbell M. D.

Feb 6, 1923 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westwood N. J.

DATE OF BURIAL 2/8 1923

20 UNDERTAKER J. Frew McCarthy

ADDRESS 130 E. Fort

mation should be carefully supplied. AGE should be stated. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72104 HEALTH DEPARTMENT—CITY OF BALTIMORE D72104

CERTIFICATE OF DEATH. 1/4-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 507 E. 17th St. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E Christian

(a) RESIDENCE NO. 507 E. 17th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Christian

6 DATE OF BIRTH (month, day, and year) March 4 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm Christian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary Christian (Address) 507 E 17th St

15 Filed Feb 6 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

6-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) February 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31st, 1923, to Feb 5th, 1923, that I last saw h[illegible] alive on Feb 5th, 1923, and that death occurred, on the date stated above, at 10.10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. W. Montgomery M. D.

2/6/23 (Address) 401 E 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem't DATE OF BURIAL Feb 8 1923

20 UNDERTAKER Wilhelm Bal 502 E Balto ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Died minutes time
from Spring time
Hospital.
Ok J. H. Collins M.D.
Coroner
2/6/23

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72105 D72105

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Scott

(a) RESIDENCE No. 106 Penn St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
51				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed 6-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1923, to February 5, 1923, that I last saw her alive on February 4, 1923, and that death occurred, on the date stated above, at 12:05 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Belle

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Clyde McNeil M. D.

2-5-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 2-7 1923

20 UNDERTAKER Emil Easton ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72106

CERTIFICATE OF DEATH.

144 D72106

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: No. University Hospital St.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Reynolds

(a) RESIDENCE. No. 205 Bath St ST., WARD. Cambridge Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Reynolds

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge, Maryland

PARENTS

10 NAME OF FATHER John Heat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sylvia Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records

15 Filed FEB 6-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1923, to Feb. 4, 1923.

that I last saw her alive on Feb 4 1923.

and that death occurred, on the date stated above, at 12.15 A m.

The CAUSE OF DEATH* was as follows: Post Partum Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Atony of Uterus

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical Symptoms + Findings

(Signed) T. Norwood Wilson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 2-7 1923

20 UNDERTAKER Wm. Easton

ADDRESS 916 Pa ave

mation should be carefully supplied. All items should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72107

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH (city)

Registered No. C.....

City of BALTIMORE: (No. Franklintown, Md. St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar Comengair Redding

(Residence in Baltimore: No. Franklintown, Md. St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. Oct. 15, 1843
(Month) (Day) (Year)

7-AGE. 79 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Packer
(b) General nature of industry, business, or establishment in which employed (or employer): Oyster Co.

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. William A. Redding

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Margaret Wright

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Redding

(Address) Woodlawn P.O. Md.

15- FEB 6 1923 Robert P. Harris, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 5th 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) no contrib.

(Duration) yrs. mos. ds.

(Signed) J. T. Kennedy M. D.
(Coroner.)

Feb. 6 1923 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	Feb 7 1923

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N. Paca St.

If state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72108

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1301 W. Ostend St. ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Townsend

(a) RESIDENCE NO. 1301 W. Ostend St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Townsend

6 DATE OF BIRTH (month, day, and year) Feb. 4" 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Mr. Porter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) U.S.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown

14 Informant Charles E. Townsend
(Address) 1301 W. Ostend St.

Filed 1923 Robert P. Harrison
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5" 19 23

17 I HEREBY CERTIFY, That I attended deceased from Jan 1923, to Feb 1923.

that I last saw her alive on Feb 1923,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clifford Dorsey, M. D.

2/6, 19 23 (Address) 1227 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Feb 8" 1923

20 UNDERTAKER Joseph L Cook

ADDRESS 1003 N Bath St

mation should be carefully supplied. AGE should be stated EXACTLY. Physicians CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

FEB 6

Spec.—1-10-21—M&T—1500 Bks.

(Hart)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72109

D72109

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1803 N. Bethel ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rose Hart.

(a) RESIDENCE NO. 1803 N. Bethel. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married,~~ Widowed, ~~or Divorced~~, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 15/1852

7 AGE: Years 70 Years; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House

(b) General nature of industry, business, or establishment in which employed (or employer): wife

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: Patrick Hart.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Rose Graben.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mrs. John P. McWilliam

(Address) 1803 N. Bethel St.

15 Filed ....., 19.....

Robert P. Harrison, Registrar

Burial Permit Clerk.

6-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-4 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 0, 1922, to Feb 4-, 1923.

that I last saw her alive on Feb-4-, 1923,

and that death occurred, on the date stated above, at 7-15 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos 14 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) E. Gill Hall, M. D.

Feb 6 1923 (Address) 1617 E North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: Feb. 17 1923

20 UNDERTAKER: George J. Ruxton — ADDRESS: 1735 Hayford av.

mation should be carefully supplied. AGE should be stated EXACTLY. Ambiguous terms CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1/72110 HEALTH DEPARTMENT—CITY OF BALTIMORE D72110

CERTIFICATE OF DEATH. X 135

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John A. Beck

(a) RESIDENCE NO. 863 Cumberland Memphis, Tenn ST., WARD Memphis Tenn.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 686

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) La.

PARENTS

10 NAME OF FATHER Christian Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Susanna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address)

15 Filed 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1923, to Feb. 5, 1923, that I last saw him alive on Feb. 5, 1923, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Post-Operative Shock.

(duration) yrs. mos. 3 hrs. ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Tennessee

Did an operation precede death? Yes Date of 2-5-23

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings.

(Signed) Eugene F. Shaw, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Memphis Tenn. DATE OF BURIAL 2/6/23 19

20 UNDERTAKER H. F. Hughes ADDRESS 424 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D72111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72111 90

CERTIFICATE OF DEATH.

Registered No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. John Hopkins Hosp ... St.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Bareman

(Residence in Baltimore: No. 519 St. Eutaw Street ... St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	White	S

6-DATE OF BIRTH, Sept 22, 1918 (Month) (Day) (Year)

7-AGE, 4 yrs. 4 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Morris Bareman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Jennie Rosenberg

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Balto St

15- Filed FEB 7 - 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 — 6, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis

(Duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) ... yrs. 3½ mos. ... ds.

(Signed) J. S. T. Gailey M. D. (Coroner.)

2-6 1923. (Address) 508 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Mount Auburn Cem. DATE OF BURIAL, Feb. 7, 1923

20-UNDERTAKER Jack Lewis ADDRESS ~~[illegible]~~ 1439 E. Balto

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If unknown approximate as nearly as may be. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Valley View Ave ST., Belair Rd WARD) 26

2-FULL NAME John J. Gilmarran.

(a) RESIDENCE NO. 3 Valley View Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos ..... ds.

REGISTERED NO. 129 D72112
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Exact statement of OCCUPATION should be carefully supplied. AGE should be given CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29, 1835

7 AGE — Years: 88 — Months: 7 — Days: 7 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Peddler retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas Gilmarran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Susan Hinton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Geo Mosser
(Address): 1442 E Gay

15 Filed ..... 19 ..... Registrar
FEB 7 - 1923 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1923, to Feb 5, 1923, that I last saw him alive on Feb 5, 1923, and that death occurred, on the date stated above, at 10 Lo P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) P yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) A. L. Williamson, M. D.
2/6/, 1923 (Address) Raspeburg, Balt, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Feb 7 1923

20 UNDERTAKER: Geo Mosser — ADDRESS: 1442 E Gay

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72113

CERTIFICATE OF DEATH.

16 V D72113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2935 Cedar Ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sattler

(a) RESIDENCE. No. 2935 Cedar Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 5, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Jos. B. Sattler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Bridie M. Manion

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Jos. B. Sattler
(Address) 2935 Cedar Ave.

15 FEB 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1923, to Feb. 5, 1923, that I last saw him alive on Feb. 5, 1923, and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. A. Macht, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — DATE OF BURIAL Feb 7 1923

20 UNDERTAKER Chenowith Son — ADDRESS Chestnut ave

mation should be carefully supplied. Any [illegible] may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

145-002

D72114

CERTIFICATE OF DEATH.

REGISTERED NO. D72114

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1055 N. 43rd ST. 13 WARD)

2-FULL NAME Estella M Brooks

(a) RESIDENCE NO. 1055 N. 43rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie Brooks

6 DATE OF BIRTH (month, day, and year) Dec 17 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER Jesse McCandless

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Sophia Jesse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD

14 Informant Jesse Brooks (Address) 1055 N 42 St.

15 FEB 7 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 6 1923, to Feb 6 1923,

that I last saw h[illegible] alive on Feb 6 1923,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Shock, Following difficult child-birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Fay, M. D.

, 19 (Address) 12 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — DATE OF BURIAL Feb 9 1923

20 UNDERTAKER Ashenworth & Son — ADDRESS Spencer Ave

mation should be carefully supplied. AGE should be stated in years, months and days if it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Birkenwald

D72115

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 001 D72115

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2226 Callow Ave ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Birkenwald

(a) RESIDENCE NO. 2226 Callow Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Birkenwald

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Joseph Rosenstock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Adelaide Rosenstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant Mr Usman

(Address) Vermont Ave

15 Filed FEB 7-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1920, to Feb 5, 1923, that I last saw h[illegible] alive on Feb 5, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis, Hypertension (duration) about 4 mos. years ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Theodore H. Marman M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Herbert Friendship Cemetery DATE OF BURIAL Feb 7 1923

20 UNDERTAKER J. Ahrens & Bro ADDRESS 1611 Madison Ave

mation should be carefully supplied. AGE should be stated in years. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D72116 HEALTH DEPARTMENT—CITY OF BALTIMORE D72116

CERTIFICATE OF DEATH. 46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Horwitz

(a) RESIDENCE NO. 919 E. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lehrman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Sacks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant H. Horwitz

(Address) 919 E. Baltimore St

15 FEB 7-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1923, to Feb. 6, 1923, that I last saw h[illegible] alive on Feb. 6, 1923, and that death occurred, on the date stated above, at 5:40 a m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Ovaries with Metastases to Lungs, Peritoneum, Etc.

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Moses Tellman, M. D.

2/6 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Cemetery Pur	2/7 19 23
20 UNDERTAKER S. Levinson & Bro	ADDRESS 1127 E. Balto St

mation should be carefully supplied. AGE should be stated PARTICULARLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks. Sartoph ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72117 57 D72117

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 E. Balto ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Sartoph

(a) RESIDENCE NO. 2100 E. Balto ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 48 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jos Horwitz

(Address) 355 S Calhoun st

15 Filed FEB 7 - 1923 ROBERT R. KRAUER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/6. 1923

17

I HEREBY CERTIFY, That I attended deceased from March, 1922, to Feb. 6, 1923, that I last saw h[e] alive on Feb. 6, 1923, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 2 yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Sartaloune, M. D.

2/6, 1923 (Address) 1810 Eutaw st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Rd — DATE OF BURIAL: 2/7 1923

20 UNDERTAKER: S. Levinson & Bro — ADDRESS: 127 E Balto

mation should be carefully supplied. AGE should be stated in years and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72118 | CERTIFICATE OF DEATH. | 101-001 D72118

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 212 Hawthorne Road WARD 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Beall Mullikin

(a) RESIDENCE. No. 212 Hawthorne Rd. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James McElderry Mullikin

6 DATE OF BIRTH (month, day, and year) Oct 25 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	3.	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chas Co Md

PARENTS

10 NAME OF FATHER John A Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Md

12 MAIDEN NAME OF MOTHER Anna Beall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chas Co Md

14 Informant James Mullikin (Address) 212 Hawthorne Rd

15 Filed FEB 7-1923 ROBERT R. KRAUER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/1 1923, to 2/6 1923, that I last saw h[illegible] alive on 2/6 1923, and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

Feb 7 1923 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem DATE OF BURIAL Feb 8 1923

20 UNDERTAKER John D. Mitchell ADDRESS 1201 Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be given. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72119

CERTIFICATE OF DEATH.

D72119

Registered No. C. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1413 W Fayette St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Albaugh

(Residence in Baltimore: No. 1413 W Fayette St.; 73 yrs. 11 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed or Divorced (Write the word)
Male	White	Married

6-DATE OF BIRTH. Feb (Month) 22 (Day) 1849 (Year)

7-AGE. 73 yrs. 11 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Grafton Albaugh

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Albaugh

(Address) 1413 W Fayette St

15. Filed FEB 7 - 1923 ROBERT R. KRAMER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 6 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & heart

(Duration) suddenly yrs. mos. ds.

(Signed) James W. Poulson M. D. (Coroner.)

Feb 6 1923 (Address) 1 W E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Feb 8 1923
20-UNDERTAKER.	ADDRESS
John D. Mitchell	120 N. Fayette St

N. B.—Every effort should be made to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72120 HEALTH DEPARTMENT—CITY OF BALTIMORE D72120

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Carey St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roberta Parker Smith

(a) RESIDENCE NO. 1111 Carey St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Petersburg Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Clarence Parker

(Address) Williamsburg Va

15 Filed FEB 7 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/5 - 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/10, 1923, to 2/5 - , 1923,

that I last saw h[illegible] alive on 1/5 - , 1923,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency &
Chr. nephritis

(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burk Clarke, M. D.

2/6, 1923 (Address) 2119 Dr[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL (Cambridge md

DATE OF BURIAL Feb. 7 1923

20 UNDERTAKER Joseph A Farrell

ADDRESS 2319 Pinkney

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72121

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72121

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 Lemon ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Grace Presco

(a) RESIDENCE. NO. 1311 Lemon ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 23. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Maryland

PARENTS

10 NAME OF FATHER James Elias Presco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md

12 MAIDEN NAME OF MOTHER Mary Ella Byrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fredericksburg. Va

14 Informant Mary Sadtler

(Address) 311 E. Lemmon st

15 Filed FEB 7 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7 1923. to Feby 4th 1923.

that I last saw her alive on Feby 3, 1923.

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH was as follows:

Lobular Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) continuous yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. T. Tippett M. D.

, 19 (Address) 132 W. Lombard st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Feb 7th 1923

20 UNDERTAKER A. Jones ADDRESS 111 S. Gilmor st

mation should be carefully supplied. Write plainly. Words should be properly classified. Exact statement of occupation is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is necessary. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72122

CERTIFICATE OF DEATH.

124 D72122

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

2-FULL NAME Nellie Nicholas

(a) RESIDENCE NO. 135 Colvin St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

nation should be carefully supplied. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Chew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 7 - 1923 ROBERT R. KRAUTER Registrar Burial Permit, City.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from January 6, 1923, to February 5, 1923, that I last saw her alive on February 4, 1923, and that death occurred, on the date stated above, at 6:45 A.M. The CAUSE OF DEATH* was as follows:

Multiple abscess of liver.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cholecystitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? and yes.

What test confirmed diagnosis? Path.

(Signed) Clyde M. Reed, M. D.

2-5-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL Feb 7 1923

20 UNDERTAKER John W. Hendrson

ADDRESS 1504 E Monument

Spec.—1-10-21—M&T—1500 Bks.

D72123

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D72123

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 N. Central Ave ST.; 5 WARD)

2-FULL NAME Eliza Dixon

(a) RESIDENCE NO. 425 N. Central Ave WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: general domestic

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Mamie Allen
(Address) 221 N. Edward St

15 Filed FEB 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1922 to Feb. 4, 1923.

that I last saw h[illegible] alive on Feb. 4, 1923.

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary): Infirmities Age

(duration) yrs. — mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Isabel Robinson M. D.

2/6, 1923 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury

DATE OF BURIAL: Feb 7 1923

20 UNDERTAKER: John E Henderson

ADDRESS 501 Eutaw

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D72124

REGISTERED NO. D72124

D72124

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO. 1429 Bounty Lane ST.: 13 WARD)

2-FULL NAME Joseph Thomas

(a) RESIDENCE. NO. 1429 Bounty Lane ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fatima

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 40

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Thomas
(Address) 1429 Bounty Lane

15 Filed FEB 7 - 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1923, to Feb 6, 1923, that I last saw h. alive on Feb 5, 1923, and that death occurred, on the date stated above, at 11 15 a.m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) valvular heart disease

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Edward Fisher, M. D.

2-6 1923 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Asbury

DATE OF BURIAL Feb 7 1923

20 UNDERTAKER John W Henderson

ADDRESS 1523 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Certificates of certificates. See instructions on back of certificate. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72125 D72125

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1827 E. Eager St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mabel Washington

(Residence in Baltimore: No. 1827 E. Eager St.; yrs. 18 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

Single, Married, Widowed or Divorced. (Write the word.) Single

6-DATE OF BIRTH. Unknown (Month) 1 (Day) (Year)

7-AGE. 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). At home

9-BIRTHPLACE. (State or Country). Fredericksburg Va

PARENTS:

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Henderson

(Address) 1502 E. Monument St.

15- FEB 7 - 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb (Month) 5 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to end death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Partially Tuberculosis

(Duration) yrs. mos. ds.

(Signed) J. S. H. Baller M. D. (Coroner.)

2 6 1923 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Fredericksburg DATE OF BURIAL. Feb 7 1923

20-UNDERTAKER. John W Henderson ADDRESS 1502 E Monument

R. S. 8—Every item of the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of cause of death is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

Gadum

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72126 | CERTIFICATE OF DEATH. | 124 D72126

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1621 John St ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Louis Fadum

(Residence in Baltimore: No. 1621 John St

St.; 35 yrs., 6 mos., 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. March (Month) 18 (Day), 1855 (Year)

7-AGE. 67 yrs. 10 mos. 19 ds.

If LESS than 1 day. ....hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Machinist
(b) General nature of industry, business, or establishment in which employed (or employer). Do

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Julius Fadum

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Krimer

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wife Mrs. J. L. Fadum

(Address) 1621 John St

15-

FEB 7 - 1923

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feby (Month) 6 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany 24 1923, to Feby 6 1923, that I saw him alive on Feby 6 1923, and that death occurred, on the date stated above, at 3.30a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Gangrenous Cyst Bladder

(Duration) 1 yrs. ....mos. 2 ds.

(Signed) H L Kolrich M. D.

....., 191... (Address) 718 W 7th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Western Cemetery

DATE OF BURIAL. 2, 1923

20-UNDERTAKER Wm Cooke

ADDRESS 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72127

REGISTERED NO. 11-001 D72127

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 N Exeter St. ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa DeLuca

(a) RESIDENCE. NO. 437 N Exeter ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Frank DeLuca

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Lucchesi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Frank DeLuca
(Address) 437 N Exeter Street

15 Filed FEB 7 - 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 6, 1923, that I last saw h[er] alive on Feb 6, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Influenza

1 day (duration)

Broncho Pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Leon Gerstung, M. D.

, 19 (Address) 1906 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb. 7 1923
20 UNDERTAKER Wm Cooke - 502 E.	ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72128

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 D72128

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. John & Lafayette ST., 4 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lauretta Maria Bontelle

(a) RESIDENCE NO. 324 North Eutaw ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? 76 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of George B Bontelle

6 DATE OF BIRTH (month, day, and year) ? ? 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work.... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) New Ipswich
(State or country) New Hampshire

PARENTS

10 NAME OF FATHER Wilson

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Frank M. Bontelle
(Address) 3524 Lewis Ave. Cincinnati Ohio.

15 Filed FEB 7 - 1923 19 ROBERT R. KRAUTER, Registrar
~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2-23 19 . to Feb. 6 . 1923.
that I last saw her alive on Feb. 6 . 1923.
and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Brian E Talmadge M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manchester New Hampshire

DATE OF BURIAL 2/8 1923

20 UNDERTAKER William Cook

ADDRESS Baltimore

mation should be carefully typewritten. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D72129 HEALTH DEPARTMENT—CITY OF BALTIMORE D72129

CERTIFICATE OF DEATH.

REGISTERED No. C 11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 Mypotte Av St. L WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman Lairs.

(Residence in Baltimore: No. 1523 Mypotte Av St. about 7yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 21 (Day), 1893 (Year)

7-AGE, 30 yrs. 7 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Auto Repairer
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Wm D Laws

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Millie Briggs

13-BIRTHPLACE OF MOTHER (State or Country) Alabama Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mella Laws

(Address) 1523 Mypotte Ave

15-

Filed ....FEB 1 1923...., 191.....

ROBERT R. KRAUTER
Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 7 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 4 1923, to Feb. 7 1923, that I saw h[illegible] alive on Feb. 6 1923, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

(a) Bronchio-Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. 12 ds.

(Signed) [illegible] M. D.

Feb 7, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Loud Mt. Woodlawn Cem. DATE OF BURIAL, 2/8, 1923

20-UNDERTAKER Samuel F. Lemley ADDRESS 578 N Bradford St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is important. See instructions on back of certificate.

JUN 19 1923

D 72129

Personally appeared before me this
19th Day of June 1923 Mrs Millie Laws
mother of Norman Laws who makes affadavit
that the residence of Norman Laws in Baltimore City
should be about 7 years also birth place of
Millie Griggs should be Alambama instead of
Ind. also place of burial should be Coan Wharf
Avalon. Virginia

Seal. Millie Laws Mo

Seal George H Grese
Notary Public

arcinoma, Sar-
i; "Cancer" is
for malignant
ugh; Chronic
itial nephritis;
intercurrent)
nportant. Ex-
eath), 29 *ds.*;
ds. Never re-
litions, such as
matic), "Atro-
ulsions," "De-
."), "Dropsy,"
morrhage," "In-
Shock," "Ure-
ite disease can
ys qualify all
miscarriage, as
AL *peritonitis*,"
operation was
tate MEANS OF
JICIDAL, HOMI-
sible to deter-
tal drowning;
evolver wound
arbolic acid—
njury, as frac-
e., sepsis, teta-
of "Contribu-

ldditional infor-
wing diseases,
e of death:

Convulsions,
Meningitis,
Peritonitis,
, Tetanus.

a Coroner:

ial negligence
les, Abortions
/ or indirectly

Spec.—6-9-19—H. P. Co.—1000 Bks.

Lucy Simms ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72130

CERTIFICATE OF DEATH.

90 D72130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611- Gold ST.: 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Simms

(a) RESIDENCE. No. 611 Gold ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Simms

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Genl Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) James Simms 611 Gold St

FEB 7-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1922, to Feb 5, 1923, that I last saw h— alive on Feb 5, 1923, and that death occurred, on the date stated above, at 6A. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Indefinite.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical Exam

(Signed) R. Garland Griffith, M. D.

Feb 6, 1923 (Address) 1334 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loms Chapel Northumberland Co Va	Feb. 8 1923
20 UNDERTAKER	ADDRESS
Jos. R. Downs	Madison

mation should be furnished, if known. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D72131 D72131

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Dukeland ST., 15 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth Stedding

(a) RESIDENCE No. 1604 Dukeland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 16 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 20-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	1	10	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Owen G. Stedding

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Minnie C. Neal

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Owen G. Stedding
(Address) 1604 Dukeland st

15 FEB 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 5 1923

17
I HEREBY CERTIFY, That I attended deceased from
Feb 6" , 1923 , to Feb 5" , 1923 ,
that I last saw h~~e~~ alive on Feb 5" , 1923 ,
and that death occurred, on the date stated above, at 8 10 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Hubert E. Zapp, M. D.

Feb 6 1923 (Address) 3048 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Feby 9 1923

20 UNDERTAKER Harry W. Ehlen — ADDRESS 1744 W. North

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D72132

D72132

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 1 WARD)

2-FULL NAME Laura Haskoska

(a) RESIDENCE NO. 3044 Poston St. ST., 1 WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	44	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Hungary (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Hungary (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 7-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from February 4, 1923, to February 4, 1923, that I last saw her alive on February 4, 1923, and that death occurred, on the date stated above, at 11:05 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 24? yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis of liver (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? Refused

What test confirmed diagnosis?

(Signed) Clyde O'Neill, M. D.

2-5-, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery

DATE OF BURIAL Feb. 8 1923

20 UNDERTAKER Lilly & Zeiler

ADDRESS 405 S. Wolfe St.

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72133

CERTIFICATE OF DEATH.

9 D72133

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2314 Jefferson ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Samuels

(a) RESIDENCE. (No. 2314 Jefferson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 20/22

7 AGE: Years | Months: 2 | Days: 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Harris Samuels

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Minnie Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Balto

15 FILED FEB 7 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1923, to Feb 7, 1923, that I last saw h[er] alive on Feb 7, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Israel Gaylor M. D.

2/7, 1923 (Address) 700 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rehrer Rosedale

DATE OF BURIAL: 2/9 1923

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto

Spec.—1-10-21—M&T's 500 Blks.

D 2134

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D72134

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 Fred'k ave ST., 19 WARD)

2-FULL NAME Sally Goldman

(a) RESIDENCE NO. 1809 Fred'k ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. [illegible] ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jac Col. P Goldman

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 45; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Joseph Caplin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jacob P. Goldman

(Address) 1809 Fredrick ave

15 Filed FEB 7 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 19 23

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 19 22, to July 7, 19 23

that I last saw h[illegible] alive on July 7, 19 23

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis Lymphatic Gland's (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? 1

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theo. Kaercher, M. D.

July 7 1923 (Address) 1736 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Hebrew Woods Rd — DATE OF BURIAL: 2/7/1923

20 UNDERTAKER: Jack Levin — ADDRESS: 1439 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72135

CERTIFICATE OF DEATH.

31 D72135

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3119 Dillon ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace M. Stallings

(Residence in Baltimore: No. 3119 Dillon St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Jan. (Month) 3 (Day), 1901. (Year)

7-AGE, 22 yrs. 1 mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jacob F. Kirkwood

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Md

12-MAIDEN NAME OF MOTHER Ella Donaldson

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. D. Stallings

(Address) 3119 Dillon St

15-

Filed ....., 191.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 6th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1 1922, to Feb. 6 1923, that I saw h[illegible] alive on Feb. 6 1923, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ..... (Duration) ....yrs. ....mos. ....ds.

(Signed) R. C. Metzel M. D.

Feb. 6, 1923 (Address) 1903 Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, Feb. 9, 1923

20-UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last residence or OCCUPATION important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72136

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1407 N. Bond ST., 7 WARD)

2-FULL NAME William Benjamin

(a) RESIDENCE No. 814 N. Patterson Park Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Benjamin

6 DATE OF BIRTH (month, day, and year): Sept. 19, 1842

7 AGE — Years: 79 — Months: 4 — Days: 18 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

8 1/5

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Samuel Benjamin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Elizabeth Coleman

(Address) 420 2 Brentwood Ave

15 1923 Robert P. Harrison, .19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1922 to Feb 6 1923

that I last saw h[illegible] alive on Feb 6 1923

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) [illegible] M. D.

2 6 1923 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Feb 9 1923

20 UNDERTAKER: Fickler & Fickler — ADDRESS: 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

87-1923

D72137

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72137

66

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE (No. 731 So. Bond St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lind

(Residence in Baltimore: No. 731 So. Bond St.; Yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. Aug (Month) 7th (Day) 1870 (Year)

7-AGE. 52 yrs. 5 mos. 29 ds. If LESS than 1 day, ...hrs. or.....mdn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Sebastian Lind

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Katherine Kaufmann

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Lind

(Address) 604 So. Wolfe St

15- Robert P. Harrison, 192.....

Burial Permit Clerk Registrar.

7 - 1923

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 6th (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Thos A. Norton M. D.
(Coroner)

Feb 7th 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Balto Md

19-PLACE OF BURIAL OR REMOVAL. Mt Carmel — DATE OF BURIAL. Feb 8 1923

20-UNDERTAKER. Peter Nicolaus — ADDRESS Eastern Av

Spec.—8-24-14—M. & T.—2000 Bks.

D72138

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72138

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 John ST.; 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Boyd Macon Martin Jr.

(Residence in Baltimore: No. 1505 John St St.; X yrs., X mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH, 2 (Month) 5 (Day) 1923 (Year)

7-AGE, X yrs. X mos. 1 ds. If LESS than 1 day, X hrs. or X min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (infant)
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Boyd Macon Martin Jr.

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Helen Chandler Perkins

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Boyd M. Martin

(Address) 1505 John St

15-

Filed Robert P. Garrison Registrar.

37 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 6 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-5 1923, to 2-6 1923, that I saw him alive on 2-6 1923, and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Syncope due to cerebral anemia due to strangulation of umbilical cord (ex utero) before or during labor (Duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion due to Syncope (Duration) X yrs. X mos. 1 ds.

(Signed) P Bulleon M. D.

2/7, 1923 (Address) 1124 W. Lafayette Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ft. Lincoln

DATE OF BURIAL, Feb. 7, 1923

20-UNDERTAKER Wm Cook

ADDRESS E North Av

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72139

CERTIFICATE OF DEATH.

190 D72139

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Women Home ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Carter

(a) RESIDENCE. NO. 1400 N Lexington ST., WARD. New Windsor Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wht	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co (State or country) Md

PARENTS

10 NAME OF FATHER Wm H Selby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hannah Duffy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alex J Jones

(Address) Calhoun & Maccubbin Lexington

15 Filed Feb 9 1923 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 6, 1923, that I last saw h alive on Feb 6 1923, and that death occurred, on the date stated above, at 6 30 p m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Senile Cedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Woodward M. D.

Feb 9, 1923 (Address) 1532 Fagan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Windsor Md

DATE OF BURIAL Feb 9 1923

20 UNDERTAKER George J Smith

ADDRESS 1532 Hollins

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72140

CERTIFICATE OF DEATH.

D72140

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 N Monroe ST., 16 WARD)

2-FULL NAME Mary A Theisz.

(a) RESIDENCE NO. 805 N. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Theisz.

6 DATE OF BIRTH (month, day, and year) March 2 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper.

(b) General nature of industry, business, or establishment in which employed (or employer) 108

(c) Name of employer Emma. Ann Belz Exec

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER not known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary E Theisz

(Address) 805 N Monroe St

15 Filed Robert P. Harrison, Registrar

7-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1923, to Feb 6, 1923.

that I last saw h alive on Feb 4, 1923.

and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 23 ds.

CONTRIBUTORY (Secondary) Sarcoma

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Oliver Muray, M. D.

, 19 (Address) 1221 W. Fayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: 2-8 1923

UNDERTAKER: Mrs Chas A Rohde — ADDRESS: 600 N Arlington Ave

mation should be carefully supplied. AGE should be stated EXACTLY. If UNDER ONE YEAR or OVER ONE HUNDRED YEARS should the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72141

CERTIFICATE OF DEATH.

D72141

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: No. 726 Penna Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Preston Jones

(a) RESIDENCE. No. 726 Pennsylvania ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? All his birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE: Years 39 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Restaurant Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer): Serving Boarders

(c) Name of employer

1886

9 BIRTHPLACE (city or town) (State or country): S. C.

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't Know

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant (Address): Allie Jones 726 Pennsylvania ave

15 Filed 2-7-1923, 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1923 to Feb 4, 1923, that I last saw h living on Feb 4, 1923, and that death occurred, on the date stated above, at 2 10 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) John L Stewart, M. D.

2-7 1923 Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 2-9 1923

20 UNDERTAKER: David Earhart

ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2-7-1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72142

101-001 D72142

CERTIFICATE OF DEATH.

REGISTERED No. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 513 Walnut St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Brown

(a) RESIDENCE. No. 516 Walnut St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, (~~HUSBAND of~~) (or) WIFE of: Jno. Brown

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE: Years 38 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Benj Hamstall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Carolina Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Carolina Archibald 513 Walnut St.

15 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to July 5, 1923.

that I last saw her alive on July 4, 1923

and that death occurred, on the date stated above, at 2 A- m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary): Carcinosis

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam

(Signed) Wm Schley Nutt M. D.

(Address) 1716 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Burn

DATE OF BURIAL: 2-9-23

20 UNDERTAKER: Emil Easton

ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. Informant CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

87-1923

Spec.—1-10-21—M&T—1500 Bks.

D72143

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72143

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1915 N. Patterson Pl. Place WARD)

2-FULL NAME Naomi Baker

(a) RESIDENCE NO. 1915 N. Patterson Pl. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Lloyd J. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Bona

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York City

14 Informant Lloyd J. Baker (Address) 1915 Patterson Park

15 Jan 7 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

B 7—1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 7 1923

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1923, to January 6, 1923.

that I last saw her alive on , 19

and that death occurred, on the date stated above, at 12:05 A.M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Frederick L. Hanes, M. D.

Jan. 19 23 (Address) 1301 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bonds Cemetery

DATE OF BURIAL Jan 9th 1923

20 UNDERTAKER Wm Cook

ADDRESS City

mation should be carefully supplied. AGE should be stated in YEARS. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72144 44 D72144

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1205 N Charles ST., 11 WARD)

2-FULL NAME Margaret Teresa Swentzel King

(a) RESIDENCE No. 1205 N Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm R. King

6 DATE OF BIRTH (month, day, and year): Sept 5-1852

7 AGE — Years: 70 — Months: 5 — Days: 2 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Penna

PARENTS

10 NAME OF FATHER: Wm Frederick Swentzel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Margaret Teese

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): Rev. Wm Swentzel Ainslee apts

15 FEB 7 - 1923 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/7/23 19

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 ..... to Feby 7th 1923.

that I last saw h[illegible] alive on Feby 7th 1923.

and that death occurred, on the date stated above, at 10.15 A m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma with Anasarca

(duration) 2 yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gustav Goldman, M. D.

, 19 (Address) 656 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. — DATE OF BURIAL: 2/10 1923

20 UNDERTAKER: Chas P. Evans & Son — ADDRESS: 1180 Mt Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72145

CERTIFICATE OF DEATH.

179 D72145

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 E. Gustav ST., 10 WARD)

2-FULL NAME Olivia E. Geisendaffer

(a) RESIDENCE NO. 1217 E. Gustav ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) Sept. 5-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Saml Kunst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Saml Kunst

12 MAIDEN NAME OF MOTHER Matt Kunst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Saml Kunst

14 Informant Jack Louis Andersen (Address) 1217 E. Gustav St.

15 Filed 1923 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1923, to Feb. 6, 1923, that I last saw h.r alive on Feb. 6, 1923, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Necessary tests

(Signed) [illegible] M. D.

F. D. 1923 (Address) 1210 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Feb 8- 1923

20 UNDERTAKER Chas. E. Evans & Son ADDRESS 1187 W. Mt. Royal

FEB 7-1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72146

D72146

CERTIFICATE OF DEATH.

100-0

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 Eutaw Place ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Lobe

(a) RESIDENCE NO. 1807 Eutaw Place ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 95 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isaac Lobe

6 DATE OF BIRTH (month, day, and year): Aug. 18, 1821

7 AGE — Years: 101 Months: 5 Days: 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Holland

PARENTS

10 NAME OF FATHER: Simon Eytinge

11 BIRTHPLACE OF FATHER (city or town) (State or country): Holland

12 MAIDEN NAME OF MOTHER: Leah Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Holland

14 Informant: Mr. N. Lobe (Address) 1807 Eutaw Place

15 2-8-1923 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6 19 23

17 I HEREBY CERTIFY, That I attended deceased from Feb 4 , 19 23 , to Feb 6 , 19 23 ,

that I last saw h alive on Feb 6 , 19 23 ,

and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Old Age) (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julius Friedenwald, M. D.

, 19 (Address) 1 E. Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem.

DATE OF BURIAL: 2/8/1923

20 UNDERTAKER: David Londheim

ADDRESS: 118 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72147

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D72147

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 935 S. Paca ST., 21 WARD)

2-FULL NAME Anna Schmidl

(a) RESIDENCE NO. 935 S. Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30-1919.

7 AGE — Years: 3 Months: 3 Days: 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry Schmidl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Augusta Geisendaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Henry Schmidl

(Address)

15 Filed Feb 7 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1923, to Feb 6, 1923, that I last saw h alive on Feb 6, 1923, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Rutland Dunn, M. D.

19 (Address) 1111 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Feb 8 1923.

20 UNDERTAKER: James Dignan & Son — ADDRESS: 1000 S. Paca st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D72148

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72148

CERTIFICATE OF DEATH.

REGISTERED NO. 93

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (NO. Lombard ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Carroll.

(a) RESIDENCE. NO. Mr Elkton, Md. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie Carroll.

6 DATE OF BIRTH (month, day, and year) 1886.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Adison Foote

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Landon Carroll.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Houser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Carroll
(Address) Childs Md R.D

15 Filed Nov 15, 1922 C S Grant Registrar

7-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/23 1922

17 I HEREBY CERTIFY, That I attended deceased from 10/25, 1922; to 11/23, 1922

that I last saw h[illegible] alive on 11/23, 1922

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Cortex Carcinoma

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) Ivan Jordan M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Grove Cem Pa	Nov 25 1922

20 UNDERTAKER	ADDRESS
C. S. Grant	Elkton Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72149

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipla Hospital. ST., 75 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Bernard

(a) RESIDENCE NO. 1237 Letitice Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	----	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maine

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Mary Ann Foot

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Municipal Hospital Records.

15 Robert P. Harrison, Registrar, 19

Burial Permit Clerk.

87-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 4 1923

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1923, to February 4, 1923, that I last saw him alive on February 4, 1923, and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Syphilis

(duration) / yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clyde Moore, M. D.

2-5-, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Feb 8 1923

20 UNDERTAKER: Jos Jacobs & Son

ADDRESS: 217 S. Bro

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D72150

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D72150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2209 E Pratt ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Buckley

(a) RESIDENCE No. 2209 E. Prat ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Thomas Buckley

6 DATE OF BIRTH (month, day, and year) December 9 1820

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5 3	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Frank Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Pappa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs. Lillian Smith

(Address) 233 N. Edwards Ave

15 Robert P. Harrison, Registrar

19 Burial Permit Clerk.

57-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1923, to Feb 5, 1923, that I last saw h[illegible] alive on Feb 5, 1923, and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical Sign

(Signed) Leo. Keller, M. D.

Feb. 19 23 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross. Stafford Rd DATE OF BURIAL Feb 8. 1923

20 UNDERTAKER Wendell J Hippel ADDRESS 1001 Wash St.

Information should be carefully supplied. Note that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D72151 — CERTIFICATE OF DEATH — D72151

154-003

1 PLACE OF DEATH (Wilson House) — REGISTERED NO. C

CITY OF BALTIMORE (No. Herman Hospital for Crippled Children WARD) Stiles Ave Baltimore Md.

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Wilson House

(Residence in Baltimore: No. Ellicott City Md St.; yrs. 1 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	white	Single

6 DATE OF BIRTH December 25th, 1922 (Month) (Day) (Year)

7 AGE yrs. 1 mos. 12 ds. — If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ellicott City Howard Co Md

PARENTS

10 NAME OF FATHER Ellsworth House

11 BIRTHPLACE OF FATHER (State or country) Howard County.

12 MAIDEN NAME OF MOTHER Marriott, Agnes.

13 BIRTHPLACE OF MOTHER (State or country) Balto. County

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. Tunstall Taylor M.D.

(Address) 1102 N. Charles St.

15 Robert P. Harrison, 191 Burial Permit Clerk. REGISTRAR

B 7 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 6th, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 28, 1922 to February 6 1923.

that I saw him alive on .191 .

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Hare Lip & Cleft Palate

Inanition. Cardiac Weakness

(Duration) yrs. 1 mos. 12 ds

Contributory (SECONDARY) Cyanosis & Asthenia

(Duration) yrs. mos. ds.

(Signed) R. Tunstall Taylor M. D.

2-6, 1923 (Address) 1102 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. 1 mos. 3 ds. In the State yrs. 1 mos. 12 ds.

Where was disease contracted, If not at place of death? At Home

Former or usual residence Ellicott City Md.

19 PLACE OF BURIAL, OR REMOVAL — M. Olivet Cem Cremation Md. — DATE OF BURIAL — Feb. 8, 1923

20 UNDERTAKER Easton Sons — ADDRESS Ellicott City

B. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72152 D72152

CERTIFICATE OF DEATH.

43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28-Whittemore Ave. 70 WARD)

2-FULL NAME George Richard Knight

(a) RESIDENCE NO. 28-Whittemore Ave WARD Violetteville

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Knight

6 DATE OF BIRTH (month, day, and year): July 22-1848

7 AGE: Years 74 Months 6 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Md.

PARENTS

10 NAME OF FATHER: Jacob Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Mrs. Annie Knight (Address) 28 Whittemore Ave Catonsville, Md.

15 Filed 19 Robert F. Harrison, Registrar

Burial Permit Clerk

7-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from March, 1920, to Feb. 5-, 1923, that I last saw him alive on Feb. 5-, 1923, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (mm) cheek.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Haywood W. Jones, M. D.

, 19 (Address) Augusta & Frederick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery DATE OF BURIAL Feb 7 1923

20 UNDERTAKER: F. B. Wiltyard ADDRESS 2236 Fredk Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Mabee

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72153 D72153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 819 W. Fayette St. St., 18 Ward) 170 Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Delvern Walter Mabee

(Residence in Baltimore: No. 819 W. Fayette St. St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Sept (Month) 22 (Day) 1860 (Year)

7-AGE. 42 yrs. 4 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country). Ohio

PARENTS.

10-NAME OF FATHER. Delvern Mabee

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Mary Ashbourne

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Mabee

(Address) ~~819~~ 1819 W. Fayette

15- Filed 1923 Robert P. Harrison; 192 Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 5 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ~~(Inquest, autopsy or Inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound in Brain

(Duration) a few mins. yrs. mos. ds.

CONTRIBUTORY (Secondary) Suicide

(Duration) yrs. mos. ds.

(Signed) H K Gonce M. D. (Coroner.)

2-7 1923 (Address) 11 W. Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cemetery DATE OF BURIAL. Feb 8th 1923

20-UNDERTAKER. F. B. Wiseman ADDRESS 223 E. Fayette

U. S.—Every item of information should be properly classified. Exact statement of OCCUPATION may be necessary to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72154 HEALTH DEPARTMENT—CITY OF BALTIMORE D72154

CERTIFICATE OF DEATH. 1852

1-PLACE OF DEATH Mercy Hospital Registered No. C.....

City of BALTIMORE: (No. ..... St. 11 Ward)

2-FULL NAME Charlotte Rebecca Hopwood

(Residence in Baltimore: No. 300 W. Lanvale St. 30 yrs. ..... mos. ..... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH Oct. (Month) 22 (Day) 1846 (Year)

7-AGE. 76 yrs. 3 mos. 15 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. John Copeland

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. Delilah Everhart

13-BIRTHPLACE OF MOTHER, (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Austin Hopwood

(Address) 300 W. Lanvale St

15- Robert ....

Feb 7 1923 192.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 6 (Month) (Day) 192 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquest, aforesaid find that said deceased came to his death (Autopsy or Inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Fibrature Hip

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. C. Slade M. D.

(Coroner.)

192.... (Address) 1126 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	Feb 8 1923
20-UNDERTAKER. Wm Fluckner Sons	ADDRESS North Pa

State CAUSE OF DEATH in plain terms, so that it may be properly classified. This is very important. See Instructions on back of certificate.

D72155

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72155

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1915 Lemmon St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Gries

(Residence in Baltimore: No. 1915 Lemmon St.; yrs. 56 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	widow

6-DATE OF BIRTH. May (Month) 21 (Day) 1847 (Year)

7-AGE. 75 yrs. 8 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Gosch

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Gries

(Address) 1915 Lemmon St

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

87-1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 5 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) Inquiry find that said deceased came to hey death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Clavicle

Accident by falling

Congenital Debility

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. 8 ds.

(Signed) James M Kenton M. D.
(Coroner.)

Feb 6 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL	DATE OF BURIAL.
Our Cathedral	Feb 8, 1923
20-UNDERTAKER	ADDRESS
George L. Schwab	701 Eutaw St

Spec.—1-10-21 M&T 1500 Bks.

D72156

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72156

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4734 (ST.) Pimlico Rd (WARD) 26

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Blanche Reed

(a) RESIDENCE NO. 4734 (ST.) Pimlico Rd (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Reed

6 DATE OF BIRTH (month, day, and year): Aug. 28, 1884

7 AGE — Years: 38 — Months: 5 — Days: 10 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James W. Dunnigan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Katherine Lowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: John Reed (Address) 4734 Pimlico Rd.

15 Filed: Robert P. Harrison, Registrar

7-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Month, 1910, to Feb. 7, 1920.

that I last saw her alive on Feb. 6, 1923

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Acute pneumonia

Substernal.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Examination

(Signed) Month, M. D.

, 19 (Address) 3429 Chelsea Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. — DATE OF BURIAL: Feb 1923

20 UNDERTAKER: Wm. J. Pickerell & Sons — ADDRESS: Mortuary

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D72157

HEALTH DEPARTMENT—CITY OF BALTIMORE

10 D72157

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 Traymore Road ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Mary Kuhn

(Residence in Baltimore: No. 301 Traymore Road St.; 2 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. Write plainly. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept. (Month) 5 (Day), 1914 (Year)

7-AGE, 8 yrs. 5 mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work at School and
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), West Winfield N. Y.

PARENTS.

10-NAME OF FATHER, Joseph E. Kuhn

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Henrietta H. Snow.

13-BIRTHPLACE OF MOTHER (State or Country) West Winfield N. Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. J. Kerr

(Address) 156 N. Luzerne

15- FEB 8 - 1923 Filed ....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 7 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 4 1923, to Feb 7 1923, that I saw h[illegible] alive on Feb 7 1923, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Toxic Impregnation

Focal Lesion

Pharyngeal (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Epilepsy & Chorea (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Carl Jelliffe M. D.

Feb 7, 1923 (Address) 4106 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Feb 9, 1923

20-UNDERTAKER Jos. J. Kerr ADDRESS 156 N Luzerne

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72158

CERTIFICATE OF DEATH.

57 D72158

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1067 N. Carolina ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Friedman

(a) RESIDENCE NO. Bridgeport, Conn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Friedman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurses-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Hoodman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lish —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Baltimore

15 Filed FEB. 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1923, to Feb. 7, 1923.

that I last saw her alive on Feb. 7, 1923,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia —

Cardiac Dilatation.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus, Hypertension about 4 yrs. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1067 N. Carolina St

Did an operation precede death? No Date of Feb. 7, 1923

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Harry Friedman, M. D.

, 19 (Address) 1404 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bridgeport Conn

DATE OF BURIAL 2/8 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore St

mation should be clearly supplied. Avoid the use of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

72159

Spec.—1-10-21—M&T—1500 Bks.

D72159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~D72168~~ D72159

REGISTERED NO. 1129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Moreland Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Shapiro

(a) RESIDENCE NO. 1613 Moreland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Shapiro

6 DATE OF BIRTH (month, day, and year): 1846

7 AGE: Years 77 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Levy 1439 Eastern Ave

15 Filed FEB 8-1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1922, to Feb 7, 1923, that I last saw h[illegible] alive on Feb 6, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): chronic nephritis (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) Jacob Leeber, M. D.

2/7, 1923 (Address) 2235 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehren Herring Run — DATE OF BURIAL 2/8 1923

20 UNDERTAKER: Jack Levy — ADDRESS 1439 E Balto

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. Note that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72160

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 N Washington ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Kocourek

(Residence in Baltimore: No. 925 N Washington St.; 10 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 73 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Anton Stecher

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Magdalene Shanek

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Kocourek

(Address) 130 N Martin St

15- Filed FEB 8-1923, 191.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 7 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1 1923, to Feb 7 1923, that I saw h[illegible] alive on Feb 7 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Valvular Heart Disease

..... (Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm C Kupernik M. D.

Feb 7, 1923 (Address) 824 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Feb 10, 1923
20-UNDERTAKER	ADDRESS
Jos Broelsch	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every question must be answered. Use figures for dates. Be particular and write plainly. All items are important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72161 D72161

CERTIFICATE OF DEATH.

161-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 Jefferson ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Kragl

(Residence in Baltimore: No. 1827 Jefferson St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, Feb (Month) 4 (Day), 1923 (Year)

7-AGE, ...yrs.....mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Henry Kragl

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Albena Dolejska

13-BIRTHPLACE OF MOTHER (State or Country), Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Kragl

(Address) 1827 Jefferson St

15-

Filed FEB 8-1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 7 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 5 191.., to Feb 7 191..,

that I saw h.. alive on Feb 7 191..,

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Prematurity Birth

..... (Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs....mos....ds.

(Signed) Wm O Pegues M. D.

Feb 7, 1923 (Address) 5112 Kenwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Oak Hill

DATE OF BURIAL, Feb 8, 1923

20-UNDERTAKER Frank Cracknon Son

ADDRESS 1906 Eutaw

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M & T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72162

CERTIFICATE OF DEATH.

15 101-001 D72162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3715 Towanda ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David U Selensky

(a) RESIDENCE No. 3715 Towanda ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Haddassa Selensky

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ..min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 Eutaw st

15 Filed FEB 8 - 1923, 19 ... ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/2, 1923, to 2/7, 1923, that I last saw h in alive on 2/7, 1923, and that death occurred, on the date stated above, at 7.50 P m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

2/7, 1923 (Address) 733 Arguilla st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL Feb 8 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Baltimore

Information should be carefully supplied. AGE should be given for the last birthday. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

D72163

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167 D72163

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2701 Pennsylvania Ave 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Percy H Gladstone

(Residence in Baltimore: No. 2701 Pennsylvania Ave (Length of residence in Baltimore: yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH, ... 2 (Month) ..... 2 (Day), 1880 (Year)

7-AGE, 42 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lamp Lighter
(b) General nature of industry, business, or establishment in which employed (or employer): Lighter

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles A Gladstone

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis H Davis

(Address) 7 E Camden St

15-

Filed FEB 8 - 1923, 191. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb (Month) ..... 6 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral Hemorrhage (Over)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

....., 191.. (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park — DATE OF BURIAL, Feb 9, 1923

20-UNDERTAKER William Cook Sr — ADDRESS 926 North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Hanug

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72164

D72164

CERTIFICATE OF DEATH.

109-02 D72164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2842 Harford Rd ST. 9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Pf Hanug.

(a) RESIDENCE NO. 2842 Harford Rd ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Jan 6 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at Home

(b) General nature of industry, business, or establishment in which employed (or employer) ..... do

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Gotthard Hanug

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elmendinner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Gotthard Hanug.
(Address) 2842 Harford Rd

15 FEB 8 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1922, to Feb 7, 1923,
that I last saw h- alive on Feb 6, 1923
and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
complicated Heart
and Kidney trouble

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

, 192 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	Feb. 10 1923
20 UNDERTAKER	ADDRESS
Wm Cook	101 E Hartford

mation should be carefully supplied. AGE should be stated in years. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No infectious disease

Cause not known.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72165

CERTIFICATE OF DEATH.

129 D72165

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3422-Guilford-Terrace ST., 12 WARD)

2-FULL NAME FLORENCE MANAHAN.

(a) RESIDENCE No 3422-Guilford-Terrace ST., 12 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 54 yrs. 8 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (None-Single)

6 DATE OF BIRTH (month, day, and year) May-27-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	54	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buyer of the Ladies'

(b) General nature of industry, business, or establishment in which employed (or employer) Corsets at store

(c) Name of employer Hutzler Brothers Co.

9 BIRTHPLACE (city or town) (State or country) Westminster CarrollCo.,Md.

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER Jane (not known)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westminster Carroll Co., Md.

14 Informant Miss Annie C. Huggins (friend)
(Address) 3422-Homewood-Terrace.

15 FEB 8-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6- 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 2- 1923 to Feb 6. 1923.
that I last saw h- alive on Feb 6. 1923
and that death occurred, on the date stated above, at 11-56 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albuminuria

(Signed) W. H. Peard M. D.

. 19 (Address) 2105 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster, CarrollCo. Md. DATE OF BURIAL: Feb-8-23

20 UNDERTAKER: [illegible] & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) ADDRESS 108 W. NORTH AVE.

IMPORTANT—Physician, Undertaker and Informant should read carefully. CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr Pearce
210 N Charles St

Chr. Bright's Disease

Spec.--1-10-21--M&T--1500 Bks.

D72166 HEALTH DEPARTMENT—CITY OF BALTIMORE

3 D72166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kneller

(a) RESIDENCE NO. 210 E. pratt st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Kneller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Graft

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

8-1923 19 Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1923, to Feb. 6, 1923, that I last saw him alive on Feb. 6, 1923, and that death occurred, on the date stated above, at 10.50 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglisca M. D.

2-7-1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manchester Maryland

DATE OF BURIAL Feb 9 1923

20 UNDERTAKER John P. Denny

ADDRESS 7. S. Eight St

BURIAL PERMIT SHOULD BE CAREFULLY SUPPLIED. NONE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72167 D72167

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1308 W Pratt ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary R Bayle (Boyle)

(a) RESIDENCE NO. 1308 W Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank O. Boyle

6 DATE OF BIRTH (month, day, and year): December 1877

7 AGE: Years 46 Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Michael Shannahan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Michael J. Boyle

(Address): 1308 W. Pratt St.

15 FEB 8-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1923, to February 6, 1923, that I last saw h-d alive on February 6, 1923, and that death occurred, on the date stated above, at 2 15 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

Apoplexy.

(duration) yrs. mos 2 ds. 9

CONTRIBUTORY (Secondary): Endocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Nitsch M. D.

2/7, 1923 (Address) 2151 Talbot ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery — DATE OF BURIAL: Feb 7 1923

20 UNDERTAKER: Joseph L. Cook — ADDRESS: 1063 W Balto St

Having charge of Certificate of Death. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72168

CERTIFICATE OF DEATH.

145-0 D72168

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Wilkens Ave ST., 19 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lillian Basil

(a) RESIDENCE NO. 421 S. Gilmore ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of ~~(or WIFE of)~~ Charles T. Basil

6 DATE OF BIRTH (month, day, and year) June 13th 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	39	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John B. Fullemkamp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Theresa MacCarthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Charles T. Basil

(Address) 421 S. Gilmor St.

15 FEB 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8. 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 8, 1923,

that I last saw her alive on Feb 8, 1923

and that death occurred, on the date stated above, at 4.25 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Myocardial simplicity -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of Feb 7 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical -

(Signed) Karl J. Strinmueller, M. D.

2/8, 1923 (Address) 327 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Feb. 10 1923

20 UNDERTAKER: Joseph B. Cook ADDRESS: 1003 N. Eutaw St.

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Caesarean Section

Spec.—1-10-21—M&T—1500 Bks.

D72169

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D72169

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 Anchor St. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Sparks Cramschuper

(a) RESIDENCE NO. 1413 Anchor St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22-192

7 AGE — Years: ~~11~~ Months: 11 Days: 16. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Cramschuper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Viola Sparks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm Cramschuper

(Address) 1413 Anchor St.

15 Filed FEB 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1923, to Feb 6, 1923

that I last saw h~~im~~ alive on Feb 6, 1923

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Primary)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinically

(Signed) H. L. Hamperk M. D.

Feb 7, 1923 (Address) 1649 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem

DATE OF BURIAL: 2/8/1923

20 UNDERTAKER: John F. Fahey & Sons

ADDRESS: 1318 Light St

mation should be carefully supplied. Avoid abbreviations. Write plainly with ink. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D72170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 S. Fifth St. ST., 76 WARD)

2-FULL NAME Anna Tallagsen.

(a) RESIDENCE NO. 800 S. Fifth St. ST., 76 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl J. Tallagsen.

6 DATE OF BIRTH (month, day, and year) April 4-1867.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Carl H. Tallagsen (Address) 800 S. 5th St.

15 Filed FEB 8-1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5 1923.

17 I HEREBY CERTIFY, That I attended deceased from 2-2, 1923, to 2-5, 1923, that I last saw her alive on 2-4, 1923, and that death occurred, on the date stated above, at 11.00 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Not

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Kerschbaumer M. D.

2/6, 1923 (Address) 2439 Gallows

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz, Cem.

DATE OF BURIAL Feb. 8 1923.

20 UNDERTAKER Lilly & Zeltz.

ADDRESS 403 S. Mt. St.

Spec.—1-10-21—M&T—1500 Bks.

Dr. Lemmon

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72171

CERTIFICATE OF DEATH.

100-001

D72171

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3710 Mc Elder St. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dolores Elliott

(a) RESIDENCE NO. 3710 Mc Elder St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Elliott

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Hilda Smith

13 BIRTHPLACE OF MOTHER (city or town) New Jersey. (State or country)

14 Informant Daniel Elliott

(Address) 3710 Mc Elder St.

15 Filed FEB 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 4 , 1923 , to Feb 6 , 1923 ,

that I last saw her alive on Feb 6 , 1923 ,

and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

acute Bronchio Pneumonia

(duration) yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Bronchio Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) John B Lemmon M. D.

2/8, 1923 (Address) 718 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	Feb. 8 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72172 — 74-001 — D72172

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3133 Dillon St.; 1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Michael M. Cooney

(a) RESIDENCE. No. 3133 Dillon St., 1 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bridget Cooney

6 DATE OF BIRTH (month, day, and year): Aug 12 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired 073
(b) General nature of industry, business, or establishment in which employed (or employer): R.R. Switchman
(c) Name of employer: Penna. R. R

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS
10 NAME OF FATHER: John Cooney
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Ellen Haley
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Bridget Cooney 3133 Dillon St

15 Filed , 19 FEB 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1923, to Feb 6, 1923, that I last saw him alive on Feb 5, 1923 and that death occurred, on the date stated above, at 10.50 m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

CONTRIBUTORY (Secondary): Cerebral Hemorrhage (duration) 3 yrs. mos. ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M J McAvoy, M. D.

2/8, 1923 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cem — DATE OF BURIAL: Friday Feb 9/23

20 UNDERTAKER: Lilly & Zuber — ADDRESS: Lilly & Zuber 417 S. Fremont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72173

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72173

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3914 East ave ST., No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Long

(a) RESIDENCE NO. 3914 East ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 5 minutes (Years / Months / Days)

If LESS than 1 day, ...hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Michael Long

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) U.S.

12 MAIDEN NAME OF MOTHER Margaret Schell

13 BIRTHPLACE OF MOTHER (city or town) Balto md (State or country) U.S.

14 Informant Michael Long (Address) 3914 East ave

15 Filed FEB 8 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-6 1923

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw him alive on 2-6 , 1923, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

6 mo abortion (accidental)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J Russell, M. D.

, 19 (Address) 157 N Milton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem,

DATE OF BURIAL: Feb 9 1923

20 UNDERTAKER: Lilly & Zeiler

ADDRESS: 403 S Wolfe

IMPORTANT—Should be carefully supplied. Note should be properly classified. Exact statement of OCCUPATION of deceased in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72174 HEALTH DEPARTMENT—CITY OF BALTIMORE 99-00 D72174

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 S Dallas ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Pearce

(a) RESIDENCE. No. 228 S Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) April 1920

7 AGE 2 Years 10 Months Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Co Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Elizeth Pearce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County

14 Informant Mother Elizeth Pearce
(Address) 32 S Dallas st

FEB 8 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 7 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4th, 1923, to Feb. 6th, 1923, that I last saw him alive on 5th, 1923, and that death occurred, on the date stated above, at 4. A. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob L Wisner, M. D.

2-7, 1923 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Feb 10 1923
20 UNDERTAKER Mrs Robert + Elliott	ADDRESS 1725 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72175 HEALTH DEPARTMENT—CITY OF BALTIMORE 94-001 D72175

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 726 Lindenave St. 11 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie Cepkes

(Residence in Baltimore: No. 726 Lindenave St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) married

6-DATE OF BIRTH, about ....., 1876
(Month) (Day) (Year)

7-AGE, 47 yrs. ..... mos. ..... ds.

If LESS than 1 day. ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... home

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Louis Chasy

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Cepkes

(Address) 726 Lindenave

15- FEB 8 - 1923 191... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 7 (Day), 1923 (Year).

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) no known

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Feb 8, 1923 (Address) 320 E Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Feb 12, 1923
20-UNDERTAKER	ADDRESS
Wm Robert & Elliott	1225 Eastern Ave

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72176

CERTIFICATE OF DEATH.

5 D72176

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Fulton Ave St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Emma R. McLeod

(Residence in Baltimore: No. Home for the Aged of the M.E. Church St.; 76 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, December 12, 1846 (Month) (Day) (Year)

7-AGE, 76 yrs. 1 mos. 26 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Henry Diggs

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER Rebecca A. Evans

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Leddy

(Address) 400 N. Fulton Ave

15-

Filed FEB 8 - 1923 191.....

ROBERT P. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Febry 7, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 20 1922, to Febry 7 1923, that I saw h-er alive on Febry 6 1923, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

.....

Diabetes

..... (Duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Uraemia

..... (Duration) ✓ yrs. ✓ mos. 3 ds.

(Signed) George C. Shannon M. D.

2/7, 1923 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet

DATE OF BURIAL, Feb. 8, 1923

20-UNDERTAKER George J. Smith

ADDRESS 1532 Hollins

N. B.—Every item of information must be given, as far as known, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72177

CERTIFICATE OF DEATH

D72177

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora Reed

(a) RESIDENCE NO. 1135 Brewer St. ST., WARD Howard Co Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	22	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co., Md.

PARENTS

10 NAME OF FATHER John Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Maryland

14 Informant Municipal Hospital Records.

(Address)

15 FEB 8-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5, 1923

17

I HEREBY CERTIFY, That I attended deceased from January 19, 1923, to February 5, 1923, that I last saw her alive on February 5, 1923, and that death occurred, on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Acute endocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Clyde Kneil, M. D.

2-6-, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Odd Fellow's Cem. Catonsville | DATE OF BURIAL 2-9-, 1923

20 UNDERTAKER Jas. Jno. Skinner | ADDRESS 1620 E. Fred. St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72178

CERTIFICATE OF DEATH.

9 D72178

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 E Church ST., 27 WARD)

2-FULL NAME William Jr Ritchie

(a) RESIDENCE NO. 216 E Church ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) March 22, 1922

7 AGE: Years ..... Months 10 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benj A Ritchie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Estella E Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Benj A Ritchie

(Address) 216 E Church St

15 Filed FEB 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1923, to Feb 7, 1923,

that I last saw h alive on Feb 7, 1923,

and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 11 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) (?) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ow Date of .....

Was there an autopsy? ow

What test confirmed diagnosis? .....

(Signed) G E Buxton, M. D.

2/8/, 1923 (Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross a a Co — DATE OF BURIAL: Feb 8 1923

20 UNDERTAKER: John F Lanny — ADDRESS: 915 Light St

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72179

CERTIFICATE OF DEATH.

100-001 D72179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 Compton ST. 24th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Miller

(a) RESIDENCE. NO. 904 Compton ST. 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~ Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Charles Miller

6 DATE OF BIRTH (month, day, and year): Nov 14, 1870

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
52	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Timothy J. Miller

(Address) 904 Compton St.

15 Filed FEB 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1923, to Feb 7, 1923, that I last saw her alive on Feb 6, 1923, and that death occurred, on the date stated above, at 12 42 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 243 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross. A A Co Md	Feb 10 1923
20 UNDERTAKER	ADDRESS
John F Denny	715 Lyon St

MATTER should be carefully supplied. ALL answers must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72180 HEALTH DEPARTMENT—CITY OF BALTIMORE D72180

CERTIFICATE OF DEATH.

REGISTERED NO. 109

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1458 Riverside a ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rita A. Jenkins

(a) RESIDENCE. NO. 1458 Riverside a ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 4, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Edw H. Jenkins

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Carroll

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Edw Jenkins
(Address) 1458 Riverside a

15 FEB 8-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 1, 1923, to Feby 6, 1923, that I last saw h er alive on Feby 6, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Vincents Angina

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) A. Leukemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Waller - H. White M. D.

2/7, 1923 (Address) 2800 St Paul st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 2/8/ 1923

20 UNDERTAKER Ed Bamming — ADDRESS 1460 Eutaw st.

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72181

CERTIFICATE OF DEATH.

100-001

D72181

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1218 Glyndon Ave. ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Joseph Cochrane

(a) RESIDENCE No. 1218 Glyndon Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1st 1922

7 AGE: Years — Months 7 — Days 6. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): /

(c) Name of employer: /

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: John. Cochrane

11 BIRTHPLACE OF FATHER (city or town) (State or country): Brooklyn N.Y.

12 MAIDEN NAME OF MOTHER: Margaret Emrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mr. John Cochrane (Address) 1218 Glyndon Ave.

15 FEB 8-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6th 1923. to Feb. 7 1923.

that I last saw him alive on Feb. 7. 1923,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchio-pneumonia,

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Ex. etc

(Signed) Thos Norton. M. D.

(Address) 888 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem.

DATE OF BURIAL: Feby 9th 1923

20 UNDERTAKER: John J. Cowan & Son per J. J. Cowan & Son

ADDRESS: 901 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. If interval since birth was CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72182 44 D72182

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3749 Cottage Ave ST., 15 WARD)

2-FULL NAME Lina Rachael Levin

(a) RESIDENCE No. 3747 Cottage Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 30 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Asher A Levin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Levin 1439 E. Baltimore St

15 Filed FEB 8-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1918, to Feb. 7, 1923, that I last saw h[illegible] alive on Feb. 6, 19..., and that death occurred, on the date stated above, at 5-40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) (after appearance of tumor)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray.

(Signed) Frank N. Krantz M. D.

Feb. 8, 1923 (Address) 927 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem DATE OF BURIAL 2-9-23

20 UNDERTAKER Jos. Levin, ADDRESS 1439 E. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. THERE SHOULD BE NO CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72183

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72183

CERTIFICATE OF DEATH.

167

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 302 S. Monroe St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christian Hugh

(Residence in Baltimore: No. 302 S. Monroe St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. May (Month) 15 (Day) 1859 (Year)

7-AGE. 63 yrs. 8 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Odd

9-BIRTHPLACE. (State or Country). Germany

PARENTS

10-NAME OF FATHER. Hugh

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Flach

(Address) 302 S. Monroe St

15-

Filed Feb 8-1923 Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb (Month) 6 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Illuminating Gas death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas
Suicide

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M. Fenton M. D. (Coroner)

Feb 8 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mount Lebanon DATE OF BURIAL. Feb 9, 1923

20-UNDERTAKER. Wilhelm & Feldmann ADDRESS 502 E Pratt St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B 8-1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72184

CERTIFICATE OF DEATH.

38 D72184

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard McDermott

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
58	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md,

PARENTS

10 NAME OF FATHER Bernard McDermott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records. (Address)

15 Filed Robert F. Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1923

17

I HEREBY CERTIFY, That I attended deceased from January 31, 1923, to February 7, 1923,

that I last saw him alive on February 7, 1923,

and that death occurred, on the date stated above, at 10:45 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 38 yrs. mos ds.

CONTRIBUTORY (Secondary) General Paresis; Acute alcoholism (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No; Refused

What test confirmed diagnosis? C. F. - C

(Signed) Clyde McNeil, M. D.

2-8-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Josephs Cem	2-10-1923
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. Particulars must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

38 - 1923

Spec.—1-10-21—M&T—1500 Bks.

D72185

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72185

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 1300 Wolfe St., H WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Whelan

(a) RESIDENCE No. 1300 Wolfe St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas A Whelan

6 DATE OF BIRTH (month, day, and year) Feb 11th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	61	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Bernard Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia Boyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records JOHNS HOPKINS HOSPITAL

(Address)

15 Robert F. Carrier, Registrar

Burial Permit Clerk.

8-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7th 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1923, to Feb 7th, 1923,

that I last saw her alive on Feb 7th, 1923,

and that death occurred, on the date stated above, at 2.05 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym - symptoms

(Signed) Guy W. Leadbetter, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Feb 9 1923

20 UNDERTAKER J. C. Medford

ADDRESS 914 Greenmount

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72186 49 D72186

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 Riverside Ave. ST., 24 WARD)

2-FULL NAME Katherine E. Marley

(a) RESIDENCE No. 1232 Riverside Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: John H Marley

6 DATE OF BIRTH (month, day, and year): Jan 5 1881

7 AGE — Years: 42 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Thomas Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Elizabeth O'Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: John H. Marley
(Address): 1232 Riverside Ave

15 Filed ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

8-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1922, to July 5, 1923.

that I last saw h[illegible] alive on 2/5/23, 19

and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma

Uterus

(duration) ... yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) X

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 11/22/22

Was there an autopsy? Phys Examination

What test confirmed diagnosis? —

(Signed) ..... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross. A.C. 60 mt

DATE OF BURIAL: Feb. 9 1923

20 UNDERTAKER: Wm Cook Sr & Youth

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pelvic Bone

Spec.—6-9-19—H. P. Co.—1000 Blks.

D72187

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72187

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 Darley av ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kidd

(a) RESIDENCE. No. 1635 Darley av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Elizabeth Kidd.

6 DATE OF BIRTH (month, day, and year) Sept 5 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Kidd.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Frank Lasingkin
(Address) 1635 Darley Ave.

15 Filed Feb 8-1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1923, to Feb 7, 1923, that I last saw h living on Feb 7, 1923, and that death occurred, on the date stated above, at 12 00 C m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W. Anderson M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery.	Feb 9 1923

20 UNDERTAKER George F. Ruth ADDRESS 1735 Hayford Ave.

B 8-1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72188

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72188

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1238 Belmont Ave ST. 27 WARD)

2-FULL NAME Adolph Gustav Steinmann.

(a) RESIDENCE NO. 1238 Belmont Ave ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Catherine Steinmann

6 DATE OF BIRTH (month, day, and year) May 24, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler 038

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Sylvester Steinmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Wenk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Karl W. Steinmann (Address) 1238 Belmont Ave

15 [illegible] 8-1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1923,

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1922. to July 6 1923.

that I last saw h[illegible] alive on July 6, 1923

and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? None.

(Signed) E. A. Bowden, M. D.

7/6, 1923 (Address) 1517 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL July 10 1923

20 UNDERTAKER George J. Rutt.

ADDRESS 1735 Harford Ave

mation should be carefully supplied. AGE, sh... should be stated EXACTLY. If LESS than ... CAUSE OF DEATH in plain terms, so that it m... it may be properly classified. Exact statement ... OCCUPA-TION is very important. See instructions on ba... on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

James Edward Hall ✓

D72189

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72189

+ 100-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Lunacy Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-FULL NAME James Edward Hall

(a) RESIDENCE NO. Ellicott City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs 2 mos. ds. How long in U. S., if of foreign birth? [redacted] mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	Unknown	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Earl Sykes Ellicott City Md

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records (Address)

15 Robert F. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-6 1923

17

I HEREBY CERTIFY, That I attended deceased from 11-17, 1922, to 2-6, 1923,

that I last saw h/m alive on 2-6, 1923,

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 21 Days

CONTRIBUTORY (Secondary) Senile Gangrene - Bed Sore

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Ellicott City

Did an operation precede death? No Date of

Was there an autopsy? Yes Clinical Findings

What test confirmed diagnosis?

(Signed) Kenneth B Jones M.D.

, 19 (Address) Maryland Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Gilboa Cemetery DATE OF BURIAL Feb. 11 1923

20 UNDERTAKER Scott M. Shaw ADDRESS Ellicott City Md

mation should be carefully supplied. AGE should be stated in YEARS. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

8-1923

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72190

D72190

CERTIFICATE OF DEATH. 1180-001

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 409 Friendship ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Stewart

(Residence in Baltimore: No. 409 Friendship St.; 74 yrs., 4 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Married

6-DATE OF BIRTH. SEP. (Month) 20 (Day), 1848 (Year)

7-AGE. 74 yrs. 4 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Wesley Johnson

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER not Known

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Stewart

(Address) 409 Friendship St

15- Robert F. Harrison

FEB 8-1923 Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. FEB (Month) 6 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from JAN 30 1923 191..., to FEB 5 - 1923 191...,

that I saw h... alive on FEB 5 - 1923 191...,

and that death occurred, on the date stated above, at 10 10 A.M.

The CAUSE OF DEATH* was as follows:

1. Bronchopneumonia of Coronal
2. Senility

(Duration)... X yrs... X mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration)... X yrs. XX mos. 7 ds.

(Signed) C. H. Burkey M. D.

FEB 8 1923, 191... (Address) 938 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Asbury Cemetery	Feb. 9, 1923
20-UNDERTAKER	ADDRESS
Chas. H. Burley	1421 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Bernardo)

D72191 HEALTH DEPARTMENT—CITY OF BALTIMORE D72191

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Pronounced dead at Registered No. C.....

City of BALTIMORE: (No. Franklin & Mare Hospital St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mollie V. Retty Bernardo

(Residence in Baltimore: No. 1207 W. Lombard St.; 25 yrs. ..... mos. ..... ds.)

1220 W. Lombard

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: March (Month) 29 (Day) 1873 (Year)

7-AGE: 49 yrs. 10 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ring Grinder
(b) General nature of industry, business, or establishment in which employed (or employer): Bartell Hayward

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: Henry Schley

11-BIRTHPLACE OF FATHER, (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Nancy Pines

13-BIRTHPLACE OF MOTHER, (State or Country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs John Hickman

(Address) 1730 W Barrington

15- Feb 8 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 6 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) Chas. M. Fenton M. D. (Coroner.)

Feb 8 1923 (Address) 100 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Feby 9 1923

20-UNDERTAKER: Chas. S. Black — ADDRESS: 742 W North ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

b 8—1923

Spec.—1-10-21—M&T—1500 Bks.

D72192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72192

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2101 Poplar Grove St., 15 Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME E. J. Victoria Fairbank

(a) RESIDENCE NO. 2101 Poplar Grove St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Fairbank

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Arlington, Balto. Co., Md.
(State or country)

PARENTS

10 NAME OF FATHER James Hale

11 BIRTHPLACE OF FATHER (city or town) Arlington
(State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Thornton

13 BIRTHPLACE OF MOTHER (city or town) Lincolnshire,
(State or country) England

14 Informant Mrs. A. V. Weeks (daughter)
(Address) 2101 Poplar Grove St.

15 Filed Feb 10 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1922, to Feby. 7, 1923, that I last saw h[illegible] alive on Jan 6 1923 and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos 21 ds.

CONTRIBUTORY (Secondary) Uterine Sclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. R. Duvall M. D.

2/8, 1923 (Address) 1817 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	2/9 1923

20 UNDERTAKER H. Cook. ADDRESS 502 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72193

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72193

CERTIFICATE OF DEATH.

100-00

I-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 500 W. Barre ST.; 22 WARD)

2-FULL NAME Naomi Baker

(a) RESIDENCE. NO. 500 W. Barre ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
f	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 2-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edwin Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Minnie Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Hayden Gamble

(Address) 500 W Barre St

15 Filed 2-8-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7/1923

17 I HEREBY CERTIFY, That I attended deceased from 1/31/1923, to 2/7/1923,

that I last saw her alive on 2/6/1923,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Disorders of Teeth

Stomatitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. Jay Bowley, M. D.

2/7/1923 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Auburn Cemetery Feb 9 1923

20 UNDERTAKER — ADDRESS

Mrs Gerkhoff for 406 N. Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D72194

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D72194

1-PLACE OF DEATH St. Agnes Hosp

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 6 WARD)

2-FULL NAME Henry Rosenfeld

(a) RESIDENCE NO. 1729 N. Montford Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16 or 18 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
74		8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Grmany

PARENTS

10 NAME OF FATHER: Carl Rosenfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country): Grmany

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Grmany

14 Informant: Albertina C. Hargreich

(Address): 1729 N. Montford Ave.

15 Filed , 19 Robert F. Harrison, Burial Permit Clerk. Registrar

8-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7- 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-6- , 1923 , to 2-7- , 1923.

that I last saw him alive on 2-7-23 , 19

and that death occurred, on the date stated above, at 8 45 - p m.

The CAUSE OF DEATH* was as follows:

Endarteritis Obliterans -

Gangrene of Right foot

Infection of Right foot

(duration) yrs 1 mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home (Over)

Did an operation precede death? yes Date of —

Was there an autopsy? No -

What test confirmed diagnosis? Clinical

(Signed) W. G. Caldwell, M. D.

2-7-, 1923 (Address) St. Agnes Hosp -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Feb 10 1923

20 UNDERTAKER: Wilbur W. Shriver — ADDRESS: 1018 Edmondson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-20-21—M&T—1500 Bks.

D72195

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72195

CERTIFICATE OF DEATH.

X 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 800 Ratorg ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie May Sterling

(a) RESIDENCE NO. 800 Ratorg ST., WARD Chester S.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 10- 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chester S. C.

PARENTS

10 NAME OF FATHER: Robert Sterling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Chester S. C.

12 MAIDEN NAME OF MOTHER: Martha Seaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wadesboro N. C.

14 Informant: Father, Robert Sterling

(Address): 800 Ratorg St

15 Filed 19 Robert F [illegible]

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1923, to Feb 6, 1923.

that I last saw h or alive on Feb 6, 1923.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No-

What test confirmed diagnosis?

(Signed) J Harry Gleason M. D.

Feb 8, 1923 (Address) 1368 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ant Hebron Lem

DATE OF BURIAL: Feb 9 1923

20 UNDERTAKER: Brown Friedland & Schuster

ADDRESS 114 N

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

8-1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72196 D72196

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 16 Talbot Road ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosabelle Drey Lauer

(a) RESIDENCE NO. 16 Talbot Rd, Windsor Hills ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Lauer

6 DATE OF BIRTH (month, day, and year): June 1st 1859

7 AGE — Years: 63 Months: 8 Days: 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Joseph Drey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma Singer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: L. Handler

(Address): 16 Talbot Rd

15 Filed: Feb 8 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 7th 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1st 1922 to Feb 7th 1923, that I last saw her alive on Feb 6th 1923, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma, Breast

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary): Generalized Metastasis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? yes Date of Oct. 1921

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam

(Signed) Eugene Heppard, M. D.

, 19 (Address) 202 Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 9th 1923

20 UNDERTAKER: Hart & Sondheim — ADDRESS: 118 N Mt Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Fractional parts CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72197

CERTIFICATE OF DEATH.

141

D72197

1-PLACE OF DEATH Womans Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lafayette & Johns ST., 20 WARD)

2-FULL NAME Mrs Jessie Vandeleur

(a) RESIDENCE NO. 1948 White Street ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Thomas J. Vandeleur

6 DATE OF BIRTH (month, day, and year) May 16 - 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	28 years	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lonaconing Maryland.

PARENTS

10 NAME OF FATHER James Lyons

11 BIRTHPLACE OF FATHER (city or town) Liverpool (State or country) England.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Scotland.

14 Informant Thomas J Vandeleur
(Address) 1948 White St

15 Filed FEB 8-1923 Robert P. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 8 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-22-23, 19..... to 1-8-23, 19....., that I last saw her alive on 2-8, 1923, and that death occurred, on the date stated above, at 4:45 A m.

The CAUSE OF DEATH* was as follows:

Fibro myocarditis

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Fibro pericarditis

(duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? (over)

Did an operation precede death? yes Date of 1-22-23

Was there an autopsy? no

What test confirmed diagnosis? Clinical & findings

(Signed) Howard Tannenbaum, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lonaconing, Md

DATE OF BURIAL 2/9/1923

20 UNDERTAKER J. J. Moran

ADDRESS 2000 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72198 113 D72198

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 N. Duncan ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos Fuchs

(a) RESIDENCE NO. 232 N. Duncan ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 9 1922

7 AGE: Years ..... Months 7. Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Jos Fuchs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER May Schwartzman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Mrs. Fuchs 232 N. Duncan St

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk.

B 8 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7 1923 to Feb ..... 19 .....

that I last saw him alive on Feb 7 1923

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary): Toxemia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. H. C. Wade, M. D.

(Address) 1436 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon

DATE OF BURIAL: July 9th 1923

20 UNDERTAKER: Geo W. Fuhrman Son

ADDRESS: 811 Woods

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72199

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72199

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 Belkis Rd., ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Bottone

(a) RESIDENCE NO. 905 Harford Ave. ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dominick Bottone

6 DATE OF BIRTH (month, day, and year): 4/3/1860.

7 AGE — Years: 62 — Months: 10 — Days: 4 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Palermo Italy

PARENTS

10 NAME OF FATHER: Vincent Buccheri

11 BIRTHPLACE OF FATHER (city or town) (State or country): Palermo Italy

12 MAIDEN NAME OF MOTHER: Anna Sagio

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Palermo Italy

14 Informant (Address): Nunzio La Grande 205 Belkis Rd

15 Filed: Robert P. Harrison, Registrar

Burial Permit Clerk.

88—1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 7, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 6th, 1923, to Feb. 7, 1923,

that I last saw her alive on Feb 7, 1923,

and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): Diabetes Mellitus

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 905 Harford Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. L. McKinnon, M. D.

2/8, 1923 (Address) Rospleig Balt, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: 2/9/23

20 UNDERTAKER: Geo. J. Ruth, — ADDRESS: 1 W Hanford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

1345 N. Charles
Fowler

D72200

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 D72200

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1331 West Pratt ST., 19 WARD)

2-FULL NAME Ruth N. Upton

(a) RESIDENCE NO. 1331 W. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 10-1920

7 AGE: Years 2; Months 8; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Charles H Upton

11 BIRTHPLACE OF FATHER (city or town) (State or country): C. C. Co Md

12 MAIDEN NAME OF MOTHER: Josephine K Metzler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Charles H Upton

(Address) 1331 W Pratt St

15 FEB 9-1923 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 30 1923 to July 9th 1923, that I last saw her alive on July 8th 1923, and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Hubbard, M. D.

, 19 (Address) 1340 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL 2/12 1923

20 UNDERTAKER: Wm Cook — ADDRESS 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72201

CERTIFICATE OF DEATH.

5 D72201

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Marks

(a) RESIDENCE NO. ? Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jack Lewis

(Address) 1439 E. Baltimore St.

15 FEB 9 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1922, to Feb 7, 1923, that I last saw him alive on Feb 7, 1923, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory

(Signed) Morris Gellman, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cem DATE OF BURIAL 2/9 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72202

CERTIFICATE OF DEATH.

100-001 D72202

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 5704 Bellona ave ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Wilner

(a) RESIDENCE. No. 5704 Bellona ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? 35 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bella. Wilner

6 DATE OF BIRTH (month, day, and year) Don't know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Abraham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarra

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Jacob Wilner (Address) Key West Fla.

15 FEB 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1921 to Feb. 8 1923, that I last saw h— alive on Feb. 8 - 1923, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Koer, M. D.

2-8. 1923 (Address) 5600 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Cemetery	2-9 1923
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72203

CERTIFICATE OF DEATH.

94-001 D72203

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Grove N. Mowell Park 25 WARD)

2-FULL NAME Anna E Schwartz

(a) RESIDENCE No. Grove N. Mowell Park ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 8 1922

7 AGE: Years | Months: 2 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John E Schwartz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Carolyn Fuches

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John E Schwartz

(Address): Mowell Park

15 Filed FEB 9 - 1923, 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 8 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1923, to Feb 8, 1923, that I last saw h-e alive on " 7, 1923 and that death occurred, on the date stated above, at 3 20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw V Callahan, M. D.

2/9, 1923 (Address) 21 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cem

DATE OF BURIAL: 2/9 23

20 UNDERTAKER: James Digman & Son

ADDRESS: 1000 S Paca St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72204

CERTIFICATE OF DEATH.

103

D72204

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129-St.Paul-Street. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Mary Tormey

(a) RESIDENCE No. 1129-St.Paul-St. ST., 11 WARD (Resident)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 1 mos. XX ds. How long in U. S., if of foreign birth? 84 yrs. 1 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard J.Tormey

6 DATE OF BIRTH (month, day, and year) Dec-28-1838.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Alfred Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Eliza Hickley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mr. Alfred J. Tormey, (son)

(Address) 1129-St.Paul-St., City.

15 Filed FEB 9 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1922, to Feb. 8th, 1923.

that I last saw h.. alive on Feb 6th, 1923,

and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Acute Hypostatic pulmonary Congestion 1 d

(duration) — yrs. — mos 1 — ds.

CONTRIBUTORY (Secondary) Senile degeneration.

5 months (duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Charles G. Hill, M. D.

, 19 (Address) Wyline and Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Feb-10-23

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 103 W. NORTH AVE

mation should be carefully supplied. AGE should be stated EXACTLY. Ale
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exa
TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72205

CERTIFICATE OF DEATH.

90 D72205

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4503 Liberty Heights Ave ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Henry Bennett

(a) RESIDENCE No. 4503 Liberty Heights Ave ST., 28 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 72 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet Ann Bennett

6 DATE OF BIRTH (month, day, and year) Nov. ? 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	72	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber & Heater

(b) General nature of industry, business, or establishment in which employed (or employer) Plumber & Heater

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore City Maryland

PARENTS

10 NAME OF FATHER Lewis H. Bennett

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Royston

13 BIRTHPLACE OF MOTHER (city or town) Clark Co. (State or country) Virginia

14 Informant Mrs. Harriet A. Bennett (Wife)
(Address) 4503 Liberty Heights Avenue

15 Filed FEB 9 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1923, to Feby 6 1923, that I last saw h[illegible] alive on Feby 6, 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac-Calapse-general (
Marasmus & emaciation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General Arterio Sclerosis.
Myocarditis (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur K. Schamberg, M. D.

2/8, 1923 (Address) 2806 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Feb. 9 1923

20 UNDERTAKER STEWART & MOWEN COMPANY

ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exa atement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72206

CERTIFICATE OF DEATH.

179 D72206

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2537 St. Paul ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily Stoviller Clarke

(a) RESIDENCE. No. 2537 St. Paul. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If ~~married, widowed or divorced~~ ~~HUSBAND of~~ ~~or~~ WIFE of: John Mercer Clarke

6 DATE OF BIRTH (month, day, and year): June 30-1836

7 AGE: Years 86 Months 7 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: Wm. S. Stoviller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary Seymour

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: J. Mercer Clarke Jr.

(Address) 2537 St. Paul St.

15 Filed 19 FEB 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1923, to Feb 7 1923, that I last saw h alive on Feb 7th 1923 and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2537 St Paul

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Presence of Urea in blood

(Signed) Clement Horn, M. D.

19 (Address) 1402 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Feb. 9 1923

20 UNDERTAKER: H. E. Hughes

ADDRESS: 4114 W. Broadway

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial Nephritis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72207

CERTIFICATE OF DEATH.

100-00 D72207

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; No. 512 N. Chester ST.; 7 WARD)

2-FULL NAME Minnie Elizabeth Bush

(a) RESIDENCE. No. 512 N. Chester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jonas Bush

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 60 yrs — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: George Steiner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Shaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Shayne Bush 512 N Chester St

15 FEB 9 - 1923 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1923, to Feby 7, 1923, that I last saw h[illegible] alive on Feby 7, 1923 and that death occurred, on the date stated above, at 9.30 p m.

The CAUSE OF DEATH* was as follows:

Bronchus = Pneumonia

(duration) ..... yrs. ..... mos. 26 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General diagnosis

(Signed) Adolph C. Steinberg M. D.

Feb 8. 1923 (Address) 1201 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Feb. 10 1923

20 UNDERTAKER: H E Stugher — ADDRESS: 1214 N. Broadway

Information should be carefully supplied. All items should be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72208

CERTIFICATE OF DEATH.

74-00 D72208

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4th St & North Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna M. Jones

(a) RESIDENCE NO. 4th St North. The Washington WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 96 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Stephen W. Jones

6 DATE OF BIRTH (month, day, and year) 1. 23 1827

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	96	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Jesse Carter

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Kathrine Kuebel

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs. H. Braden Kopf. (Address) 4 E 25 St North ave Mt Wash

15 FEB 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) F. 8. 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1922, to Feb. 8, 1923, that I last saw h-e alive on Feb 7, 1923, and that death occurred, on the date stated above, at 7.30a m.

The CAUSE OF DEATH* was as follows:

Senile degeneration

Apoplexy.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Beelen, M. D.

(Address) 1st W Washington Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Feb. 10 1923

20 UNDERTAKER H. E. Hughes — ADDRESS 4th N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

D72209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72209

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 N. Potomac ST., 7 WARD)

2-FULL NAME Adolph R. Deich

(a) RESIDENCE NO. 608 N. Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Augusta Deich

6 DATE OF BIRTH (month, day, and year) Nov 3/69

7 AGE Years 53 Months 3 Days 3 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 666

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Deich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Augusta Deich

(Address) 608 N. Potomac

15 FEB 9 - 1923

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1922 to Feb 6 1923

that I last saw him alive on Feb 6 1923,

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur J. Reysaul M. D.

2/8 1923 (Address) 801 N. Linwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem DATE OF BURIAL 2/9 1923

20 UNDERTAKER Philip Herwig ADDRESS 2016 Aliceanna

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72210

CERTIFICATE OF DEATH.

74-001 D72210

1-PLACE OF DEATH Franklin Square Hosp

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fayette Ave Calhoun St. 16 WARD)

2-FULL NAME Anna Sauerland

(a) RESIDENCE. No. 423 N. Wolfe ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Chas Sauerland

6 DATE OF BIRTH (month, day, and year) Oct 31-61

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER John Johnsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Chas Sauerland

(Address) 423 N. Wolfe

15 Filed FEB 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1923, to Feb. 8, 1923

that I last saw her alive on Feb. 8, 1923

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

Hypostatic Pneumonia

Toxaemia (Uraemic)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Cutaneous Sclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) Charles Bagott M. D.

, 19 (Address) 1207 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	2/10 19 23
20 UNDERTAKER Philip Herzig	ADDRESS 2010 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72211

11-001 D72211

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 940 Franklin Road ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Albert Trippe

(a) RESIDENCE. NO. 940 Franklin Rd. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 30 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 8, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Edward Trippe

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Edith Helen Roberts

13 BIRTHPLACE OF MOTHER (city or town) Howard County (State or country) Maryland.

14 Informant Edith H. Trippe

(Address) 940 Franklin Rd

FEB 9-1923 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 7 1923

17 I HEREBY CERTIFY, That I attended deceased from January 30, 1923, to February 7, 1923, that I last saw h[illegible] alive on February 6, 1923, and that death occurred, on the date stated above, at 12:40 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chester Riland, M. D.

2-7-1923 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL Feb 9 1923

20 UNDERTAKER David D. Hendley ADDRESS 728

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D72212 HEALTH DEPARTMENT—CITY OF BALTIMORE 11-001 D72212

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 119 N Carlton St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.. Samuel Coats

(Residence in Baltimore: No. 119 N Carlton St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	Colored	Single

6-DATE OF BIRTH. Sept (Month) 18 (Day) 1922 (Year)

7-AGE. ..... yrs. 4 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto City

PARENTS

10-NAME OF FATHER. Isaac Coats

11-BIRTHPLACE OF FATHER. (State or Country) Maryland

12-MAIDEN NAME OF MOTHER. Martha Brooks

13-BIRTHPLACE OF MOTHER. (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Brooks

(Address) 119 N Carlton St

15- Filed FEB 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 7 (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia,
Pr. by Pulmonary Displacement

(Duration) .....yrs.....mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) James M. Kinlan M. D.
(Coroner.)

Feb 9 1923 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem DATE OF BURIAL Feb 9 23

20-UNDERTAKER. Samuel Hensley ADDRESS 5[illegible]

If information should be obtained subsequently, the same should be added hereto. Every item must be answered, or a reason given why it cannot be answered. Write plainly with pen and ink. Do not use lead pencil. Be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72213

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72213

CERTIFICATE OF DEATH.

1-PLACE OF DEATH: City of BALTIMORE (No. Mercy Hospital St. 14 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Mrs. O. Smith

(Residence in Baltimore: No. 1512 Division St.) (yrs. 47) mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed or Divorced. (Write the word): Widowed

6-DATE OF BIRTH: Unknown (Month) (Day) 85? (Year)

7-AGE: 66 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cabman
(b) General nature of industry, business, or establishment in which employed (or employer): Porter

9-BIRTHPLACE, (State or Country): Not Known

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Priscilla Green

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Smith

(Address) 360 Orchard St.

15- FEB 9 - 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb. 7 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Fracture of Femur

Lobar Pneumonia

CONTRIBUTORY (Secondary) (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) H. B. Cadell M. D.

(Occupation) Phys. (Address) 443 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: Feb. 10 1923

20-UNDERTAKER: Samuel Kunda ADDRESS: 111 Eastern Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90~D72214

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2804 N. Lafayette Ave ST., 16 WARD)

2-FULL NAME Amelia R. Becker

(a) RESIDENCE NO. 2804 N. Lafayette Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a ~~If married, widowed, or divorced~~ HUSBAND of ~~or~~ WIFE of A Elmer Becker

6 DATE OF BIRTH (month, day, and year) Sept 18 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Henry. Schmitt.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER Amelia Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant A. Elmer Becker (Address) 2804 N Lafayette Ave

15 Filed FEB 9 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6 1922 to Feb 7 1923.

that I last saw her alive on Feb 7 1923.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute Diastole

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) about 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) G Patrick Cowell, M. D.

1923 (Address) 705 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL 2-10 1923

20 UNDERTAKER: Wm Chas A Gold — ADDRESS 600 N Arlington Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Result of Flu in 1918.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72215

CERTIFICATE OF DEATH.

90 D72215

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 N Appleton ST., 16 WARD)

2-FULL NAME Robert H. Hoynes

(a) RESIDENCE NO. 624 N Appleton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmina R Hoynes

6 DATE OF BIRTH (month, day, and year) Aug 5th 1845

7 AGE: Years 77; Months; Days; If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Chas Hoynes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Otto Hoynes Son

(Address) 624 N Appleton

15 FEB 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1923, to Feb 7, 1923.

that I last saw h[illegible] alive on Feb 7 1923

and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

2-7, 1923 (Address) 1466 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL 2-9 1923

20 UNDERTAKER Mrs Chas A Z Rohde — ADDRESS 600 N Arlington Ave

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72216

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

86-001

D72216

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. May Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edmund Schneider

(Residence in Baltimore: No. 1012 E Chase St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Wht

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: June (Month) 10 (Day) 1867 (Year)

7-AGE: 55 yrs. 7 mos. 28 ds. If LESS than 1 day ....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Varnisher
(b) General nature of industry, business, or establishment in which employed (or employer): 051

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Sebastian Schneider

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Annie Stenger

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary B. Schneider

(Address) 1012 E Chase St

15- FEB 9 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, Feb. 8 (Month) (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the date stated above.

CAUSE OF DEATH was as follows:

Chronic Myocarditis

Contributory Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. E. Bader M. D.

(Coroner)

Feb 9 23 (Address) 1423 N. Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: Feb 12, 1923

20-UNDERTAKER: Henry Hood & Son ADDRESS: 1301 E Eutaw St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72217

CERTIFICATE OF DEATH.

164

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2037 N. Washington ST., 8 WARD)

2-FULL NAME Mary Bruder

(a) RESIDENCE NO. 2037 N. Washington ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 90 yrs. — mos. — ds. How long in U. S., if of foreign birth? 90 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ the late Joseph Bruder

6 DATE OF BIRTH (month, day, and year) Feb. 22nd 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	90	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Anna F. Bruder

(Address) 2037 N. Washington St.

15 FEB 9 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 8 1923

17

I HEREBY CERTIFY, That I attended deceased from February, 1922, to Feb 8, 1923,

that I last saw her alive on Feb 6, 1923,

and that death occurred, on the date stated above, at 12 45 a. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

Exhaustion

(duration) several yrs. mos ds.

CONTRIBUTORY (Secondary) Infirmities

(duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. B. Carman M. D.

2-8, 1923 (Address) 1701 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	February 12 1923
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

George P Brewster

D72218

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D72218

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md General Hospital (Ward) 15

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brewster

(a) RESIDENCE NO. 1709 Ruxton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 16 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan 23, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Geo. P. Brewster Jr

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Col.

12 MAIDEN NAME OF MOTHER Edith Marshall

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

14 Informant Edith Brewster

(Address) 1709 Ruxton Ave.

15 Filed FEB 9 - 1923 ROBERT F. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 23, 1923, to Feb. 8, 1923, that I last saw him alive on Feb. 8, 1923, and that death occurred, on the date stated above, at 1.55 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No - Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical tests

(Signed) George E. Shannon, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 2/9 1923

20 UNDERTAKER Henry W. Means & Son

ADDRESS 805 N. Calvert St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

16313 (a-17)
D72219

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72219

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., No WARD)

2-FULL NAME Lula Cain

(a) RESIDENCE NO. 425 S. 6th St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 2 Weeks How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State) Virginia

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of David H. Cain

6 DATE OF BIRTH (month, day, and year) ? 1889

7 AGE: Years 33 | Months ? | Days ? | If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Brook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1923, to Feb 8, 1923, that I last saw h[illegible] alive on Feb 8 - 1923, and that death occurred, on the date stated above, at 8:15 a m.

The CAUSE OF DEATH* was as follows:

Encephalitis Letharyica

(duration) ..... yrs. ..... mos 21 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. R. Bugg, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenly.

DATE OF BURIAL 2/10 1923

20 UNDERTAKER W. E. Cook Co.

ADDRESS 502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT REQUIRED BY LAW. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72220

CERTIFICATE OF DEATH.

74-001 ✓

D72220 REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Harlem Ave. St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas J. Friel

(Residence in Baltimore: No. 1315 Harlem ave St.: 3 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 19 (Month) (Day), 1843 (Year)

7-AGE, 79 yrs. 2 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Gateman
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Phila Pa

PARENTS.

10-NAME OF FATHER, John Friel

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Margaret Clark

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. M. Friel

(Address) 1315 Harlem Ave.

15-Filed FEB 9 - 1923, 191. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 8 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 23 1923, to Feb 8 1923, that I saw h— alive on Feb 7 1923, and that death occurred, on the date stated above, at 40 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Hypertension

(Duration) yrs. mos. 5 ds.

(Signed) C. Hartman Smith M. D.

Feb 9, 1923 (Address) 517 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Md. DATE OF BURIAL, 2/10/23, 191...

20-UNDERTAKER W. J. Cunningham Son ADDRESS 517 N. Howard

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72221 46 D72221

D72221

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Francis

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Isaac Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mandy Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records

(Address)

15 FEB 9 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 19 23

17 I HEREBY CERTIFY, That I attended deceased from November 15, 19 22. to February 7. 19 23.

that I last saw her alive on February 6 . 19 23.

and that death occurred, on the date stated above, at 7:55 A.M.

The CAUSE OF DEATH* was as follows:

Adeno Carcinoma of Ovary

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) General Adeno Carcinomatosis (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of Feb-1922

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

2-7-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hot Auburn Cemetery DATE OF BURIAL Feb 10 1923

20 UNDERTAKER Mrs Geo H Hooper ADDRESS 406 Lanvale St

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D72222

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72222

CERTIFICATE OF DEATH.

REGISTERED NO. C 19·57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 N. Gilmor ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William P. Hagedorn

(Residence in Baltimore: No. 15 N. Gilmor St.; 30 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, April (Month) 14 (Day), 1864 (Year)

7-AGE, 58 yrs. 9 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): American Tobacco Co

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Hagedorn

(Address) 15 N. Gilmor St.

15 FEB 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

Filed....., 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 8th (Month) (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20th, 1923, to Feb. 8th, 1923, that I saw h.. alive on Jan. 20 1923, and that death occurred, on the date stated above, at 10.55 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) ...yrs. 7 mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. 4 mos. ...ds.

(Signed) Chas. Testa M. D.

....., 191... (Address) 210 Pearl St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	Feb. 12, 1923
20-UNDERTAKER H. Sandow & Sons	ADDRESS 1710 Eutaw St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72223

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D72223

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 N. Montford Ave ST., 6 WARD)

2-FULL NAME William H. Riefner

(a) RESIDENCE NO. 5 N. Montford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Riefner

6 DATE OF BIRTH (month, day, and year) Sept 3, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	71	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police Lieut.

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer

9 BIRTHPLACE (city or town) Balty (State or country) Md.

PARENTS

10 NAME OF FATHER John Riefner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Lemmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs H Krauter

(Address) 2401 E. Baltr St

15 FEB 9 - 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from July 2 1923, to July 6 1923, that I last saw h alive on July 5 1923 and that death occurred, on the date stated above, at 8 40 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? On duty

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Deutschmann, M. D.

, 19 (Address) 340 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Feb. 10 1923

20 UNDERTAKER H. Sander Sons ADDRESS 1700 Eod St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72224 D72224

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 North Montford Ave ST., 6 WARD)

2-FULL NAME Dorothea A. McGinnis

(a) RESIDENCE NO. 5 North Montford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. McGinnis

6 DATE OF BIRTH (month, day, and year) April 7 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER William H. Riefner

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Luft

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Charles A. McGinnis
(Address) 5 North Montford Ave

15 FEB 9 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from July 6th, 1923, to July 7th, 1923,
that I last saw her alive on July 7th, 1923,
and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Labor Puerperal

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) — yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Non Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Signs

(Signed) A. Lee Hunter, M. D.

, 19 (Address) 1348 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL Feb 10 1923

20 UNDERTAKER H. Sander Sons

ADDRESS 1710 Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72225

CERTIFICATE OF DEATH.

90 D72225

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1124 W. Franklin ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Giles

(Residence in Baltimore: No. 1124 W. Franklin St. St.; 72 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	Widow

6-DATE OF BIRTH, about ....., 184.. (Month) (Day) (Year)

7-AGE, 72 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) ..... none

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Wm Giles

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Elizabeth Smith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Giles

(Address) 1124 W Franklin St

15 FEB 9 - 1923 Filed ....., 191.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 8, 192? (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Heart disease

(Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) senile debility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Stevenson M. D. (Coroner.)

Feb 9, 192? (Address) 2 E Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR ~~REMOVAL~~,	DATE OF BURIAL,
London Park	Feb. 9, 1923

20-UNDERTAKER	ADDRESS
Geo W Little	2700 Edmondson Av

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72226

CERTIFICATE OF DEATH.

159-002

D72226

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1022 N. Carey St. ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mabel M. Dyson

(Residence in Baltimore: No. 1022 N. Carey St. St.; yrs., / mos., 11 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): single

6-DATE OF BIRTH: Dec. 27, 1923 (Month) (Day) (Year)

7-AGE: .....yrs. /....mos. 11....ds.

If LESS than 1 day .....hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): Infant

9-BIRTHPLACE (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: William N. Dyson

11-BIRTHPLACE OF FATHER (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Gladys Mallison

13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Dyson

(Address) 1022 N. Carey

15-

Filed FEB 9 - 1923 191... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb. 7, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(Duration).....yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) Premature Birth

(Duration).....yrs.....mos.....ds.

(Signed) H. T. Hennessy M. D. (Coroner.)

Feb. 8, 1923 (Address) 2802 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Laurel Cem. | DATE OF BURIAL: Feb. 9, 1923

20-UNDERTAKER: Sam H. Chase | ADDRESS: 700 Mosher

White

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72227 101-001 D72227

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., ... WARD 4)

2-FULL NAME John F. White

(a) RESIDENCE NO. 537 W. Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Dietz
(Address) 114 Washington

15 Filed FEB 9 - 1923 ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1923, to Feb 7, 1923, that I last saw h[illegible] alive on Feb 7, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. .. mos 7 ds.

CONTRIBUTORY (Secondary) Cardio-Respiratory Failure (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D. L. Berry, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Anne Annap | DATE OF BURIAL Feb 9 1923

20 UNDERTAKER John J. Fields 1120 W Lombard | ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72228
1-PLACE OF DEATH

74-001
D72228
REGISTERED NO.

CITY OF BALTIMORE: No. 14 S. Castle St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Rohm

(a) RESIDENCE. NO. 14 S. Castle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leonard Rohm

6 DATE OF BIRTH (month, day, and year): Sept 5/1845

7 AGE: Years 77 Months 5 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS
10 NAME OF FATHER: John Butzler
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger
12 MAIDEN NAME OF MOTHER: Dont Know.
13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Rev. Leonard Rohm
(Address): 14 S. Castle St.

15 Filed FEB 9 - 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1923, to Feb 7, 1923, that I last saw h[illegible] alive on Feb 4, 1923, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Senility
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) A. L. Tumbleson, M. D.
Feb 8 1923 (Address) 203 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: Feb. 10 1923

20 UNDERTAKER: Jos. J. Kerr — ADDRESS: 1566 Eastern

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72229 101-001 D72229

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Cider alley ST.; 4 WARD)

2-FULL NAME Wm H Garrison

(a) RESIDENCE. No. 704 Cider alley ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) Sept 7. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Chestertown Md
(State or country)

PARENTS

10 NAME OF FATHER Phillip Garrison

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Chester Town Md

12 MAIDEN NAME OF MOTHER Ann Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Silas Garrison
(Address) 704 Cider Alley

Filed FEB 9 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 8, 1923,
that I last saw h alive on Feb 8, 1923,
and that death occurred, on the date stated above, at 2.30 p m.
The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Symptoms

(Signed) D H Fisher, M. D.

Feb 9, 1923 Address) 715 S. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chester Town. Md

DATE OF BURIAL Feb 9 1923

20 UNDERTAKER Mrs Robert A Elliott

ADDRESS 1725 Ashland Ave Balto

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16754 D72230 D72230 X 14

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. .....

1-PLACE OF DEATH. JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Eunice S Spiegel

(a) RESIDENCE NO. West Point Ga ST., ... WARD West Point Ga.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 weeks mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Samuel Spiegel

6 DATE OF BIRTH (month, day, and year) May 21 - 1887

7 AGE — Years: 35 — Months: 8 — Days: 19 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 637

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ky

PARENTS

10 NAME OF FATHER Evan C Sittle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky

12 MAIDEN NAME OF MOTHER Elizabeth Herndon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 FILED FEB 9 - 1923 ROBERT R. KRAUTER, Deputy Health Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 6 . 1923 . to Feb 9 . 1923.

that I last saw her alive on Feb 9 - . 1923

and that death occurred, on the date stated above, at 12 25 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Septicemia (Streptococcus Erysipelas)

(duration) yrs. — mos ✓ ds.

CONTRIBUTORY (Secondary) Operation - hysterectomy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 1-13-23

Was there an autopsy? yes

What test confirmed diagnosis? Blood culture, autopsy

(Signed) I. H. Mitchell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westpoint Ga — DATE OF BURIAL: Feb 9 1923

20 UNDERTAKER: John O Mitchell — ADDRESS: 1204 Harford

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Myoma of Uterus
+ Interstitial Cystitis

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72231

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72231

CERTIFICATE OF DEATH.

11-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 143 N. Hamburg ST. 24 WARD)

2-FULL NAME George Dietrich

(a) RESIDENCE. No. 143 N Hamburg ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 010

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Adam Dietrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Brous

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna F Wottenberg
(Address) 143 W Hamburg St

15 FEB 9 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923, to Feb 7, 1923,
that I last saw him alive on Feb 7, 1923,
and that death occurred, on the date stated above, at 6 0 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

about 5
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) Wm Leibfried, M. D.

Feb 7, 1923 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Feb 10 1923
20 UNDERTAKER	ADDRESS
E Kleeman & Son	1034 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72232

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72232

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2933 Westwood ave ST.: 15 WARD)

2-FULL NAME Henry. Stehli Sr.

(a) RESIDENCE. NO. 2933 Westwood. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Florence. Stehli.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65.		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hard Wood finisher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Anthony Stehli

11 BIRTHPLACE OF FATHER (city or town) (State or country): France

12 MAIDEN NAME OF MOTHER: Barbara C. Wendel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Frank Stehli

(Address) 2931 Westwood Ave

15 Filed FEB 9 - 1923 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2. 1923, to Feb. 8. 1923, that I last saw h alive on Feb. 8. 1923, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age & Rheumatism

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinary

(Signed) Stewart C Black M. D.

2/9. 1923 (Address) 1014 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feb 9th 1923
20 UNDERTAKER: Geo Leimbach & Co	ADDRESS: 647 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72233

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72233

CERTIFICATE OF DEATH.

9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 S. Clinton ST., 12a WARD)

2-FULL NAME Dorothy M. Geho

(a) RESIDENCE No. 701 S. Clinton ST., 12a WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 25-1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Addison Geho

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Barbara Schrenfer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Addison Geho

(Address) 701 S. Clinton St

15 FEB 9 - 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1923.

17 I HEREBY CERTIFY, That I attended deceased from 11/17, 1922, to 2/9, 1923,

that I last saw h[illegible] alive on 11/8/23, 19....,

and that death occurred, on the date stated above, at 4.10 A. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

Diphtheria

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. P. Garrell M. D.

2/9, 1923 (Address) 633-S-34

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Feb 11 1923
20 UNDERTAKER Eddy & Zeller	ADDRESS 403 S. Wolfe

INSTRUCTIONS.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dipth. cleared up & House was fumigated Dec. 20/22.

Spec.—1-10-21—M&T—1500 Blks.

D72234 160858

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72234

CERTIFICATE OF DEATH.

X 131

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman F. Barron

(a) RESIDENCE No. Somerset, Pa R F D #3 ST., ... WARD Somerset Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Clara Barron

6 DATE OF BIRTH (month, day, and year): Jan 21-1882

7 AGE — Years: 41 — Months: 0 — Days: 9 — If LESS than 1 day, hrs. or min.: .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Nelson Barron

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Sadie Schafer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 9 1923, 19 .....

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 19 23, to Feb 9, 19 23,

that I last saw h[illegible] alive on Feb 9, 19 23,

and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Uremia, Pyelonephritis

2 yrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Atrophy of Kidney (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Somerset

Did an operation precede death? Yes Date of Feb. 7, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Franklin P. Johnson, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Somerset Pa.

DATE OF BURIAL: Feb. 9 1923

20 UNDERTAKER: William G. Schaeffer

ADDRESS: 1816 Monument

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72235 Red

HEALTH DEPARTMENT—CITY OF BALTIMORE

86-001 D72235

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 ..... WARD)

2-FULL NAME Sarah Lutsche

(a) RESIDENCE NO. 606 Hopson St ..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 28-1922

7 AGE: Years 1 Months — Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Wm Lutsche

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bertha Goldstrau

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Robert T. Barrazotti .19.. Registrar

FEB 9 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1922, to Feb 8, 1923, that I last saw he alive on Feb 8, 1923, and that death occurred, on the date stated above, at 2 45/60 a.m.

The CAUSE OF DEATH* was as follows:

Otitis Media & Mastoiditis (Operation)

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 1 month before

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Horton Casparis M. D.

.19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Feb 10 1923

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

USE B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72236

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1805 Lancaster St. 2 WARD)
REGISTERED NO. C 74-001

2-FULL NAME Tony Lentz

(Residence in Baltimore: No. 1805 Lancaster St.: yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Unknown

6-DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7-AGE. about 35 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Lithuania

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15- FEB 8 1923 Robert F. Harrison
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan 30th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. T. Horton M. D.
(Coroner)

Feb 6, 1923 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

Acute Mania

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, FEB 9 1923

20-UNDERTAKER Commissioner Health,

ADDRESS

FEB 9 - 1923

THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72237 HEALTH DEPARTMENT—CITY OF BALTIMORE D72237

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. 625 N. Calvert St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Shinta (or Shiata)

(Residence in Baltimore: No. 625 and 605 N. Calvert St.; yrs..... mos..... ds.)

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	

6-DATE OF BIRTH. ..... 1..... (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
..... yrs. ..... mos. ..... ds.	.... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Either Japan or China

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Robert F. Harrison, ... 192.....
Burial Permit Clerk. Registrar.

FEB 9 - 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed).....M. D.
(Coroner.)

....., 192....(Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
JOHNS HOPKINS HOSPITAL	....., 19....
20-UNDERTAKER.	ADDRESS
Commissioner Health.	FEB 9 - 1923

For Wm. S. Woodall.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72238

CERTIFICATE OF DEATH.

9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2089 Woodbury Ave St. 13 WARD)

2-FULL NAME William Robert Stine

(a) RESIDENCE. No. 2089 Woodbury Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) June 4 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Harry Stine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Mulligan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry Stine
(Address) 2089 Woodbury Ave

15 Filed Feb 9, 1923 Robert F. Carman Registrar
Burial Permit Clerk.

FEB 9-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8th, 1923, to Feb 8th, 1923, that I last saw him alive on Feb 6th, 1923, and that death occurred, on the date stated above, at 10.26 P.M.

The CAUSE OF DEATH* was as follows:

(a) Broncho-Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Whooping Cough.

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? 2089 Woodbury Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & Symptoms

(Signed) H. S. Fellat, M. D.

Feb 9, 1923 (Address) 1127 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Charles Cem	Feb 9 1923
20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72239

D72239

CERTIFICATE OF DEATH.

122-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 742 N Linwood Ave (St.) 7 (WARD)

2-FULL NAME John Samuel Shore

(a) RESIDENCE. No. 742 N Linwood Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lillian Shores

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain on Bay Boat

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co Md

PARENTS

10 NAME OF FATHER John Shores

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Tigner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co Md.

14 Informant Howard Shores

(Address) 742 N Linwood Ave

ROBERT P. LARRISON,

15 Filed ..... 19 ..... Registrar

FEB 9 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 9 1923

17

I HEREBY CERTIFY, That I attended deceased from January 5, 1923, to February 9, 1923, that I last saw him alive on January 8, 1923, and that death occurred, on the date stated above, at 9:20 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis interstitialis

Ascites

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of the Liver

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Chronic case

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. H. A. Mayar, M. D.

2-9, 1923 (Address) 2438 Linden Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lebanon Md	Feb. 11 1923

20 UNDERTAKER Martin Luskey & Son ADDRESS 1871 W North Ave

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Alcoholic.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72240

100-001 D72240

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3705 Liberty Hgts Ave ST., 15 WARD)

2-FULL NAME Mrs. Emily R. Diggs.

(a) RESIDENCE NO. 3705 Liberty Hgts Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed.

6 DATE OF BIRTH (month, day, and year) 1847.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	76.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer None.

9 BIRTHPLACE (city or town) (State or country) Charles Co., Md.

PARENTS

10 NAME OF FATHER James Brent.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co. Md.

12 MAIDEN NAME OF MOTHER Mary Neale.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co. Md.

14 Informant Mr. Anton Diggs
(Address) 1606 Madison Ave.

15 Filed FEB 9 - 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8-1923

17 I HEREBY CERTIFY, That I attended deceased from 2-2-, 1923, to 2-8-, 1923 that I last saw her alive on 2-8-1923 and that death occurred [redacted] the date stated above, at 1P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Asthma

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Merritt Sellers M. D.

, 19 (Address) 3705 Liberty Hgts Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Burial-Cathedral DATE OF BURIAL 2-10-1923.

20 UNDERTAKER Martin Fahey & Son, ADDRESS 1827 North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Sigue)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72241

11-001 D72241

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 205 Myrtle Ave (St.:) 4 (Ward)

2-FULL NAME Thelma Sigers

(a) RESIDENCE. (No.) 205 Myrtle ave (St.,) (Ward.)
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1 1921

7 AGE: Years 2 yrs; Months Jan; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ——— W.O

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): York Town. Pa

PARENTS

10 NAME OF FATHER: E Sigers

11 BIRTHPLACE OF FATHER (city or town) (State or country): York Town Pa

12 MAIDEN NAME OF MOTHER: Ella Gloden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): York Town

14 Informant (Address): Mother 618 Baker St

15 Filed 19 Robert P. Norris Registrar

FEB 9-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 28 1923, to Feb 6 1923, that I last saw h[illegible] alive on Feb 5 1923, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

(Grippe) Influenza

2 wks

(duration) yrs mos. ds.

CONTRIBUTORY (Secondary) Cold

1 wk (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 205 Myrtle ave

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm R Hoyles, M. D.

, 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Feb 7 1923

20 UNDERTAKER: Jas F Keane

ADDRESS: 213 Eastern ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72242 11-001 D72242

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3903 Norfolk Ave St., 15 WARD)

2-FULL NAME Augustine F Farley

(a) RESIDENCE NO. 3903 Norfolk Ave St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lennie Scherer.

6 DATE OF BIRTH (month, day, and year): 2/6/1880

7 AGE: Years 43 Months — Days 1 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mngr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: James Farley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Honora Donoghue

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Lennie Farley
(Address) 3903 Norfolk Ave

15 FEB 9 - 1923, 19.... Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 7, 1923, that I last saw living on Feb 7, 1923, and that death occurred, on the date stated above, at 4.10 p m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) .... yrs. .... mos 2 ds.

CONTRIBUTORY (Secondary) Influenza (duration) .... yrs. .... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R L Kuhn M.D.

19 (Address) Wentworth Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: 2/10/1923

20 UNDERTAKER: J. J. Fahey & Sons

ADDRESS: 1318 Eutaw St.

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72243

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72243

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 S. Fremont Ave ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Oleda Lowry

(a) RESIDENCE. No. 911 S. Fremont Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 17, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Thomas H. Lowry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Annie Rebecca Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Thomas H. Lowry (Address) 911 S. Fremont Ave.

15 FEB 9 - 1923 Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from August 17, 1922, to Feb 8, 1923, that I last saw her alive on Feb 7, 1923, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Rhachitis

(duration) 0 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) 0 yrs. 0 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1273 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Cem	2/11/23 19
20 UNDERTAKER	ADDRESS
J. Sabey & Sons	13, 6 Light St.

FEB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72244

CERTIFICATE OF DEATH.

11-001 D72244

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 Druid St. ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Kuhn

(a) RESIDENCE. No. 2225 Druid St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Elizabeth Kuhn

6 DATE OF BIRTH (month, day, and year) Dec 22nd 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City. Md.
(State or country)

PARENTS

10 NAME OF FATHER Jos. Kuhn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Leigh

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Elizabeth Kuhn (Wife)
(Address) 2225 Druid St.

15 Filed FEB 9-1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7 1923

17 I HEREBY CERTIFY, That I attended deceased from 1-7 1923, to 2-7 1923

that I last saw h~~e~~ alive on 2-7 1923

and that death occurred, on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ~~unknown~~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) Thos. Ruby Pitts, M. D.

2-9 1923 (Address) 919 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Feb 10 1923
20 UNDERTAKER Little & Zeiler	ADDRESS 403 Lroy

Spec.—1-10-21—M&T—1500 Bks.

D72245

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72245

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 N. Montford Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Magdalena Schubert.

(a) RESIDENCE NO. 625 N. Montford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of: Paul Schubert

6 DATE OF BIRTH (month, day, and year): Sept 12-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Attlein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Paul Schubert

(Address) 625 N. Montford Ave

15 Robert F. Hartsell, 19 Registrar

Burial Permit Clerk.

FEB 9-1923

B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of this information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 23, 1923, to Feb 6, 1923,

that I last saw h~~e~~r alive on Feb 6, 1923,

and that death occurred, on the date stated above, at 5-15 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

~~Arterio Hypertension~~ (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Alma B Lemmon, M. D.

2/8, 1923 (Address) 714 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: Feb 10 1923

20 UNDERTAKER: Wm. C. Miller

ADDRESS 2334 Pa Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72246

CERTIFICATE OF DEATH.

89

D72246

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 1232-N-Calvert ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Jefferies Buck

(a) RESIDENCE No. 1232-N. Calvert ST., 11 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 77 yrs. 10 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Chas. Edw. Buck

6 DATE OF BIRTH (month, day, and year) March-29-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	77	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Port Gibson

(State or country) Mississippi

PARENTS

10 NAME OF FATHER James Jefferies

11 BIRTHPLACE OF FATHER (city or town) not known

(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Catherine Shelby

13 BIRTHPLACE OF MOTHER (city or town) not known

(State or country) Kentucky

14 Informant Mrs Elmer Brinton daughter

(Address) 1232 N Calvert St

15 Feb 9-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-9- 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 3rd, 1923, to Feb. 9th, 1923

that I last saw her alive on 10.45 A.M., 1923,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Ag Angina Pectoris

6

one minute

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No. What test confirmed diagnosis? Clinical History

(Signed) Wilmer Brinton M. D.

, 19 (Address) 1-W. Cor. Calvert & Preston Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Port Gibson-Miss. DATE OF BURIAL July 10 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72247

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72247

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH 1705

CITY OF BALTIMORE: (No ~~1705~~ Harford ave ST., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margareth C. Crane

(a) RESIDENCE NO. 1705 Harford ave ST.; ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1/15/1838

7 AGE: Years 85 yrs. Months / Days rr If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) wife

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Crane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant George J. Ruth

(Address) 1705 Harford ave.

2-9-1923 Robert P. Harrison, Registrar

Burial Permit Cle[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/8/23 19

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6 .1923. to Feb. 8 .1923.

that I last saw her alive on Feb. 7, .1923

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) Past Year yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Benj. D. Hayden M. D.

2/8, 1923 (Address) 1216 N. Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery

DATE OF BURIAL: Feb 10 1923

20 UNDERTAKER: George J. Ruth

ADDRESS: 1705 Harford

Spec.—1-10-21—M&T—1500 Bks.

D72248

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72248

CERTIFICATE OF DEATH.

101-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 10 WARD)

2-FULL NAME Mary Montecarallo.

(a) RESIDENCE NO. 905 E. Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Michele Montecarallo

6 DATE OF BIRTH (month, day, and year): Dec-8-1879

7 AGE 43 Years 1 Months 29 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework. 037

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Italy.

PARENTS

10 NAME OF FATHER: Francesco Talvadia

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Filomena Train

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): Michele Montecarallo 905 E. Madison st

15 FEB 9-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1923, to Feb 7, 1923, that I last saw her alive on Feb 7, 1923, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Chas Wilbur Stewart, M. D.

2/7, 1923 (Address) 1738 E 28th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: 2/10/23

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1240 Hanover

F. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72249 D72249

CERTIFICATE OF DEATH.

160

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3401 Toone ST., 76 WARD)

2-FULL NAME Genevieve Krasik

(a) RESIDENCE NO. 3401 Toone ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 1 1923

7 AGE: Years — Months 1 — Days 8 — If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Krasik

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Sophia Jakubczak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Mrs Sophia Krasik

(Address) 3401 Toone St

15 Robert F. Harrison, Registrar

FEB 9 - 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 28th, 1923, to Jan 28th, 1923, that I last saw her alive on " " , 1923 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Obstruction from Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Libowitz, M. D.

, 19 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: Feb 10 1923

20 UNDERTAKER: John M. Weber — ADDRESS: 1803 Bank St

Spec.—1-10-21—M&T—1500 Bks.

D72250

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72250

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 703 S Milton ave ST., 1 WARD)

2-FULL NAME Adam Dziwanowski

(a) RESIDENCE NO. 703 S Milton ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9 1923

7 AGE — Years — Months — Days — If LESS than 1 day 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boy

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Anthony Dziwanoski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Frances Bgrowiak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Anthony Dziwanoski
(Address) 703 S Milton

15 Filed ..... 19 ..... Robert F. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1923, to Feb 9, 1923, that I last saw h[illegible] alive on Feb 9, 1923, and that death occurred, on the date stated above, at 430 p m.

The CAUSE OF DEATH* was as follows:

Atelectasis

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

What test confirmed diagnosis? .....

(Signed) Wilson J Ryan M. D.

..... 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Feb 10 1923

20 UNDERTAKER: John Weber 1803 — ADDRESS: Bank St

B 9 - 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D72251

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72251

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. M. Walter

(a) RESIDENCE NO. Daub, Md ST., WARD Daub Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs C. Walter

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland —

PARENTS

10 NAME OF FATHER: Chas. F. Walter.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lucinda Wertz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Hospital Records

(Address): University Hospital

15 Robert F. Harrison, Registrar

Burial Permit Clerk.

FEB 9 - 1923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1922 to February 9, 1923.

that I last saw him alive on February 9, 1923,

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate —

Not known (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? home —

Did an operation precede death? yes Date of Nov 22, 1922

Was there an autopsy? no.

What test confirmed diagnosis? Operation & history —

(Signed) G. C. Hatley — M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Daub Maryland

DATE OF BURIAL: 2/9 1923

20 UNDERTAKER: Robert Brodbeck

ADDRESS: Calhoun Hollins St

Spec.—1-10-21—M&T—1500 Bks.

D72252 HEALTH DEPARTMENT—CITY OF BALTIMORE D72252

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2738 E Baltimore ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George R. Hoeck

(a) RESIDENCE No. 2738 E Balto. ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ann E. Hoeck

6 DATE OF BIRTH (month, day, and year): Jan 25 1853

7 AGE: Years 70; Months; Days 14; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Patter-Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John Hoeck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Agathnow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Fred. Hoeck

(Address) 2738 E Baltos

15 Filed , 19 Registrar

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1922, to Feb 8, 1923, that I last saw him alive on Feb 7, 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 2 yrs. 6 mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Cystoscope

(Signed) Joseph J Nitelevin, M. D.

, 19 (Address) 3219 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: 2/11/1923

20 UNDERTAKER: J. J. Moran

ADDRESS 3000 E Baltos

B 101923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72253

D72253

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Williams

(a) RESIDENCE NO. 915 Curley Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Polly Williams

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Anthony Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Sarah Miner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address) M. T. H.

Filed ..., 19 ... Registrar

FEB 10 1923 Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1922, to Feb. 6, 1923, that I last saw him alive on Feb. 6, 1923, and that death occurred, on the date stated above, at 11.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Dalaglacca, M. D.

2-7-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 2-10-1923

20 UNDERTAKER David Easton

ADDRESS Balto

FEB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72254

CERTIFICATE OF DEATH.

11-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 926 Vincent ST. 16 WARD)

2-FULL NAME Martha Baynor

(a) RESIDENCE. NO. 926 Vincent ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lloyd H. Ba[illegible]

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 58 — Months — — Days — LESS 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kent County Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Jacob Baynor. 926 Vincent

15 Feb 10 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 23 1923 to Feb 8 1923

that I last saw h[illegible] or alive on Feb 3. 1923.

and that death occurred, on the date stated above, at 5. P. m.

The CAUSE OF DEATH* was as follows:

Acute Influenza over 15 ds.

(duration) yrs. [illegible] ds.

CONTRIBUTORY (Secondary): Pulmonary Hemorrhage

(duration) + yrs. + 6hr mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles E. Clark M. D.

, 19 (Address) 1306 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 2-11 1923

20 UNDERTAKER: Daniel Easton

ADDRESS: [illegible] Ave

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72255

CERTIFICATE OF DEATH.

161-001 D72255

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 600 S Linwood ST.: 1 WARD)

2-FULL NAME Eva Samsonik.

(a) RESIDENCE. NO. 600 S Linwood ST., 1 WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs ... mos ... ds. How long in U. S., if of foreign birth? ... yrs ... mos ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6 DATE OF BIRTH (month, day, and year): Feb 5 23

7 AGE — Years — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~

(b) General nature of industry, business, or establishment in which employed (or employer): ~

(c) Name of employer: ~

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Leon Samsonik

11 BIRTHPLACE OF FATHER (city or town) (State or country): Odessa Russia

12 MAIDEN NAME OF MOTHER: Mary Devine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Va

14 Informant (Address): J Somsonik 600 S Linwood St.

15 Filed 1 01923 Robert P. Harrison, Registrar

Burial Permit Clerk.

C. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EGGS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 6 1923, to Feb 6 1923, that I last saw h— alive on Feb 6 23, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Sepsis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? ~ Date of

Was there an autopsy? ~

What test confirmed diagnosis? A. L Fox

(Signed) ... M. D.

2/7, 1923 (Address) 2101 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Feb 10 1923

20 UNDERTAKER: John Grebliauckas — ADDRESS: 425 S. Paca St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72256 100-001 D72256

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Penn st ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willie Kennedy.

(Residence in Baltimore: No. 8 Penn st St.; ..... yrs., 11 mos. 18 ds.)

— Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col.

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) S.

6-DATE OF BIRTH, Feb (Month) 20 (Day), 1922 (Year)

7-AGE, ... yrs. 11 mos. 18 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Bells-

PARENTS.

10-NAME OF FATHER, Earnest Kennedy

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER Mary Brown

13-BIRTHPLACE OF MOTHER (State or Country), S C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Kennedy

(Address) 8 Penn st

15- Robert P. Harrison,

FEB 10 1923, 191.....

Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 8 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-4, 1923, to 2-8 1923, that I saw h— alive on 2-8 1923, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Kerr, M. D.

2-8, 1923 (Address) 651 W. Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL MT. ABURUM.

DATE OF BURIAL, 21 g/ ..., 191..23

20-UNDERTAKER R. L. PARHAM.

ADDRESS 220. W. HAMBURG. ST

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Hebron)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72257 100-001 D72257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 817 Pierce St. Ward 17

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hebron

(a) RESIDENCE. No. 817 Pierce St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred one yrs. one mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: colored | 5 Single, Married, Widowed, or Divorced (write the word): child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24 1922

7 AGE — Years: 1 | Months: 1 | Days: 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city

PARENTS

10 NAME OF FATHER Howard Hebron

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Elie Elbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Howard Hebron (Address) 817 Pierce St

15 Filed 10 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 25 1923 to Feb 7 1923

that I last saw him alive on Feb 7 1923

and that death occurred, on the date stated above, at 7 20 a.m.

The CAUSE OF DEATH* was as follows:

Rickets Pneumonia

(duration) yrs. mos. 1 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? own

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. K. Lanier M. D.

19 (Address) 753 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt auburn — DATE OF BURIAL: Feb 10 1923

20 UNDERTAKER: R. E. Gross — ADDRESS: 1405 McElderry St

P. S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72258

CERTIFICATE OF DEATH.

11-001 D72258

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1015 N. Wolfe ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ivy Friend

(a) RESIDENCE NO. 1015 N. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 20 1920

7 AGE: Years 3 Months — Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: James Friend

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Mary James

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant (Address): James Friend 1015 N Wolfe St

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1923. to Feb. 8, 1923.

that I last saw h[illegible] alive on Feb. 7, 1923.

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson, M. D.

(Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon DATE OF BURIAL: Feb 10 1923

20 UNDERTAKER: R C Gross ADDRESS: 1405 McElderry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 10 1923

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72259 D72259

CERTIFICATE OF DEATH.

REGISTERED No. C 4 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 W. Fayette ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vaclav Sappe

(Residence in Baltimore: No. 732 W. Fayette St.; 95 yrs. mos. ds.)

NB. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH, ... Mch (Month) ..... (Day) ....., 1 (Year)

7-AGE, 87 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Cabinet maker
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Jos. Sappe

11-BIRTHPLACE OF FATHER (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER Ant Krouza

13-BIRTHPLACE OF MOTHER (State or Country), Md Krouza

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosalie Lee

(Address) 732 W. Fayette St

15- Feb 10 1923

Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 9 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1923 to Feb 8 1923, that I saw h[e] alive on Feb 8 1923, and that death occurred, on the date stated above, at 5.30A m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Disease

(Duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred Klemm M. D.

Feb 9, 1923 (Address) 1 E Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudan Park

DATE OF BURIAL, Feb 11, 1923

20-UNDERTAKER Enoch Enochson

ADDRESS 1166 Eutaw

Crem

Spec.—8-24-14—M. & T.—2000 Bks. (1619)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72260

CERTIFICATE OF DEATH.

~~161-00~~ D72260

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Calhoun ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Watkins

(Residence in Baltimore: No. 1619 Calhoun St.; ....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb. 4th 1923 (Month) (Day), 1923 (Year)

7-AGE, ...yrs. ....mos. 4 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. md

PARENTS.

10-NAME OF FATHER, Harrison Watkins

11-BIRTHPLACE OF FATHER (State or Country). Calvert Co md

12-MAIDEN NAME OF MOTHER Fannie Harris

13-BIRTHPLACE OF MOTHER (State or Country), Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harrison Watkins

(Address) 1619 N. Calhoun

15- Robert P. Harrison, Registrar.

FEB 10 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 6, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/6 1923, to 2/8 1923, that I saw h[illegible] alive on 2/8 1923, and that death occurred, on the date stated above, at 7[illegible] m.

The CAUSE OF DEATH* was as follows:

Exhaustion
(7 Mos Birth)
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

2/6, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery

DATE OF BURIAL, Feb 11th, 1923.

20-UNDERTAKER Joseph A Farrell

ADDRESS 2319 Division St

Spec.—8-24-14—M. & T.—2000 Bks.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72261

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Eastern Av. & 24th ST., 16 WARD)

2-FULL NAME Annie E. Lenz

(a) RESIDENCE NO. Eastern Ave & 24th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of late Geo. H. Lenz

6 DATE OF BIRTH (month, day, and year) June 2/45

7 AGE: Years 77 Months 8 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Fred Meisenhalder (Address) Eastern Ave & 24th St

15 Filed 10 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1922, to Feb 7, 1923,

that I last saw h[illegible] alive on 2/4 1923,

and that death occurred, on the date stated above, at 10 35 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? [illegible] Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Arthur Chaney M. D.

2/9, 1923 (Address) 3907 Fairmount Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL 2/11 1923

20 UNDERTAKER Philip Henry — ADDRESS 2016 Orleans

C. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D72262

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 McCulloh ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Pitts

(a) RESIDENCE NO. 1211 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo W Pitts

6 DATE OF BIRTH (month, day, and year): Unknown 1881

7 AGE: Years 41 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hyde Co N. C.

PARENTS

10 NAME OF FATHER: Wm Cradle

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C.

12 MAIDEN NAME OF MOTHER: Hannah Greece

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C.

14 Informant: George W Pitt

(Address) 1211 Mc Culloh

FEB 10 1923

Filed . 19 Robert F. Halfpenny, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 9, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1923. to Feb. 8, 1923.

that I last saw her alive on 2/8/ 1923

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. ds. 5

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White M. D.

. 19 (Address) 1118 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington N.C.

DATE OF BURIAL: 2/10/ 1923

20 UNDERTAKER: Samuel T Hemsley

ADDRESS 578 W Biddle St

P.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72263

HEALTH DEPARTMENT--CITY OF BALTIMORE

D72263

CERTIFICATE OF DEATH

90

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 523 McMechen) ST. 14 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sarah Rose

(Residence in Baltimore: No. 523 McMechen St.: 8 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Unknown (Month) (Day), 1838 (Year)

7 AGE: 85 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Eastern Shore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Ebbie Knight

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sadie Hecht

(Address) 523 Mc Mechen St

15

FEB 10 1923 Robert F. Marrow, 19

REGISTRAR

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 2 (Month) 7 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923 to Feb 7 1923 that I saw her alive on Feb 6, 1923 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis and Senility

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) 4 yrs. mos. ds.

(Signed) J. Stuart Thompson M. D.

Feb 12, 1923 (Address) 1202 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn

DATE OF BURIAL: 2/10 1923

20 UNDERTAKER: Samuel T. Hemsley

ADDRESS 578 N Eddie St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72264 ✓ 161-00 D72264

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1359 N. Carey ST.: 15 WARD)

2-FULL NAME Son of Genevieve Gwynn & Clyde Patterson

(a) RESIDENCE. NO. 1359 N. Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 8. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 1359 N. Carey

PARENTS

10 NAME OF FATHER Clyde Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Castle Pa.

12 MAIDEN NAME OF MOTHER Genevieve Gwynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany Md

14 Informant Genevieve Gwynn

(Address) 1359 N. Carey St

15 Filed ..... 19 ..... Registrar

Robert P. Harrison

0123 Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1923, to Feb 9, 1923, that I last saw h[illegible] alive on Feb 8 1923, and that death occurred, on the date stated above, at 9:45 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth, 7 to 7½ months foetus.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy & Clinic

(Signed) Wm. H. Murphy, M. D.

Feb 10 1923 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 2/12/23

20 UNDERTAKER Samuel J. Hennebert — ADDRESS 578 N. Eutaw

P. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72265

CERTIFICATE OF DEATH.

D72265

REGISTERED NO. 161-01

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1359 N. Carey ST.: WARD) 15

2-FULL NAME Son of Genevieve Gwynn & Clyde Patterson

(a) RESIDENCE. No. 1359 N. Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 8, 23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 1359 N. Carey

PARENTS

10 NAME OF FATHER Clyde Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Castle Pa.

12 MAIDEN NAME OF MOTHER Genevieve Gwynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Union Bridge Md

14 Informant Genevieve Gwynn

(Address) 1359 N. Carey St

15 Filed Feb 10 1923 Robert F. Hartman Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1923, to Feb 9, 1923, that I last saw h alive on Feb 9, 1923, and that death occurred, on the date stated above, at 8.45 A.M.

The CAUSE OF DEATH* was as follows:

Premature Baby
7-7½ months Foetus,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History

(Signed) W. N. Wright M. D.

Feb 10, 1923 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	2/12 1923
20 UNDERTAKER Saml T Hagerty	ADDRESS 578 N Eden St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

FEB 10 1923

D72266

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72266

CERTIFICATE OF DEATH.

REGISTERED No. C 66

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 122 W. Pratt ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie A. Voigt

(Residence in Baltimore: No. 122 W. Pratt St St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Divorced

6-DATE OF BIRTH, June 10 (Month), 1868 (Day) (Year)

7-AGE, 54 yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Operator
(b) General nature of industry, business, or establishment in which employed (or employer): B. T. R. Co

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Meyer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William A. Mietzsch

(Address) 1220 W. Pratt St

15- Filed 5 10 1923, 191.... Robert F. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 8th, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Tobacco Bladder

(Duration) yrs. mos. ds.

(Signed) Geo Clinton Blades M. D. (Coroner.)

Feb 27 191... (Address) 1743 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Feb 10, 1923

20-UNDERTAKER Mr. Mrs. John A. Zumbrun

ADDRESS 501 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72267 11-001 D72267

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1463 Carey ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. Edward Ringgold

(Residence in Baltimore: No. 1463 Carey St.; 37 yrs., 2 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	col.	married

6-DATE OF BIRTH, Oct. 7, 1885
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
37 yrs. 9 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: undertaker
(b) General nature of industry, business, or establishment in which employed (or employer): self

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, John Ringgold

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Laura Lotman

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virgie Brooks

(Address) 1463 N. Carey St.

15-

FEB 10 1923

Robert F. Harrison
Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 8, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jany. 24 1923, to Feby. 8 1923, that I saw him alive on Feby. 8 1923, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Grip
about 3 wks.
(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary) Bronchitis (Duration) yrs. 0 7 mos. ds.

(Signed) J. E. Shamwell M. D.

Feby. 9 1923 (Address) 2226 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, Feb. 11, 1923

20-UNDERTAKER J. O. M. Johnson

ADDRESS 1234 Ethington St.

M.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72268

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72268

CERTIFICATE OF DEATH.

25179

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. South Baltimore General Hospital. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora Wheelton.

7 --- 10 --- 2.

(Residence in Baltimore: No. 42 Mason St. Masonville. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	White.	Single

6-DATE OF BIRTH. April 6, 1915. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
7 yrs. 10 mos. 2. ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General natnre of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. George Wheelton.

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Cora Duval.

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Wheelton. (father).

(Address) 42 Mason St. Masonville.

15- [illegible]

FEB 10 1923 192

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 8, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to met death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally burned about the face and body by flames from a can of burning lard (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D.
(Coroner)

Feb. 10, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death? 42 Mason St. Masonville, Feb. 3, 1923.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Feb. 13, 1923.

20-UNDERTAKER.	ADDRESS
J. J. Fahey & Sons	20, 18 Light St

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

3158

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72269

D72269

CERTIFICATE OF DEATH.

REGISTERED NO. C 100-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 146 N. High ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gilda Vitale

(Residence in Baltimore: No. 146 N. High st St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Male~~ Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, March (Month) 31 (Day), 1921 (Year)

7-AGE, 1 yrs. 10 mos. 9 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Thomas Vitale

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER Rosie Linda

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Thos. Vitale

(Address) 146 N. High st

15- Robert P. Harrison,

Filed ....., 191..... Registrar.

10/923 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 10 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 9th 1923, to Feb 10th 1923, that I saw her alive on Feb 9th 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Grippe

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Peter Testa M. D.

Feb 10, 1923 (Address) 710 Pearl st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemy

DATE OF BURIAL, Feb 12, 1923

20-UNDERTAKER Henry Hoeck Son

ADDRESS 130 E Eager st

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72270 D72270

CERTIFICATE OF DEATH.

113

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 Loudon Ave ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard L. Roe

(Residence in Baltimore: No. 513 Loudon Ave St.; 1 yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, July (Month) 15 (Day), 1921 (Year)

7-AGE, 1 yrs. 7 mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Edgar P Roe

11-BIRTHPLACE OF FATHER (State or Country), Maryland Md

12-MAIDEN NAME OF MOTHER Edith Reilly

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar P. Roe

(Address) 513 Loudon Ave

15-

Filed ....., 191.....

Registrar.

FEB 10 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 8 (Month) (Day), 1923 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Feb. 8 1923, to Feb. 9 1923, that I saw h— alive on Feb. 9 1923, and that death occurred, on the date stated above, at 10 3/4 a.m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Toxemia

(Duration) ..... yrs. ..... mos. 24 ds.

CONTRIBUTORY (Secondary) Circumcision

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Thos. H. Phillips M. D.

Feb. 9 1923. (Address) 2300 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Feb 10, 1923

20-UNDERTAKER George J Smith Hollins

ADDRESS 1532

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec. 1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72271

CERTIFICATE OF DEATH.

.66 D72271

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Zachman

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	41	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Municipal Hospital Records.

15 Robert P. Harrison, Registrar

FEB 10 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1923

17

I HEREBY CERTIFY, That I attended deceased from January 14, 1919 to February 8, 1923.

that I last saw him alive on February 7, 1923.

and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic alcoholism

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde M. Reed, M. D.

2-9-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL LOUDON PARK CEM

DATE OF BURIAL 2/10 1923

20 UNDERTAKER ROBERT BROOKS SON

ADDRESS CALHOUN HOLLINS ST

Spec.—6-9-19—H. P. Co.—1000 Blks.

(James Hoover) ✓

D72272 HEALTH DEPARTMENT—CITY OF BALTIMORE D72272

CERTIFICATE OF DEATH. 135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hospital ST.: N WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Harris (Hoover)

(a) RESIDENCE. No. 432 S Highland Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mrs Mary Harris

6 DATE OF BIRTH (month, day, and year) Apr 20 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer): Bethlehem Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Catoctin Md

PARENTS

10 NAME OF FATHER James Hoover

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Margaret Hanegan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs James Hoover
(Address) 432 S Highland Ave

15 Filed 10 1923 Robert F Harris
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1923, to Feb 8, 1923, that I last saw h in alive on Feb 8, 1923, and that death occurred, on the date stated above, at 12 N m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

Prostatic Hypertrophy (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Protestant Hospital

Did an operation precede death? yes Date of 11/21/23

Was there an autopsy? No.

What test confirmed diagnosis? Phy Exam.

(Signed) H. C. Marine, M. D.

19 (Address) 1500 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Thurmont Md — DATE OF BURIAL: Feb 11 23

20 UNDERTAKER: Wm J Pickner & Sons — ADDRESS: Thurmont Md

P. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72273

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72273

CERTIFICATE OF DEATH.

X11-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 Cold Spring Ave. WARD) 21

2-FULL NAME Mollie A. Firth

(a) RESIDENCE NO. 23 Cold Spring Ave. WARD Luray Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July 9, 1844

7 AGE — Years: 78 Months: 7 Days: 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Harry A. Rhodes

(Address) 23 Cold Spring Ave.

15 Filed FEB 10 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1923, to Feb 10, 1923,

that I last saw her alive on Feb 9, 1923,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Charles L. Warner, M. D.

, 19 (Address) 700 N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Luray Va.

DATE OF BURIAL: Feb 12 1923

20 UNDERTAKER: Wm Tucker & Sons

ADDRESS: North Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72274

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72274

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth F. Arnott

(a) RESIDENCE NO. 913 W. Balto. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Ernest (Arnott)

6 DATE OF BIRTH (month, day, and year) March 27. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41.	10.	12.	

8 OCCUPATION OF DECEASED Housewife.

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland.

PARENTS

10 NAME OF FATHER William Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Eliz. French.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant (Address) William D. Arnott 913 W. Baltimore St.

Filed 1-10 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7. 1923. to Feb 8. 1923.

that I last saw h[illegible] alive on Feb 8. 1923.

and that death occurred, on the date stated above, at 5 A.M. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) W. Isenberg M. D.

219. 1923 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Feb 17 1923

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 W. Balto St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72275 D72275 129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 N. Stricker St. ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Thomas.

(a) RESIDENCE NO. 805 N. Stricker St. ST., 16. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 63. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Thomas.

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1844.

7 AGE — Years: 78. Months: 1. Days: 16. If LESS than 1 day, hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chief Boatswain Mate

(b) General nature of industry, business, or establishment in which employed (or employer): Retired from the

(c) Name of employer: United States Navy.

9 BIRTHPLACE (city or town) (State or country): Melbourne, Australia.

PARENTS

10 NAME OF FATHER: Mr. Thomas.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Australia.

12 MAIDEN NAME OF MOTHER: Dont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Australia.

14 Informant: Mary E. Thomas.

(Address): 806 N. Stricker St.

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 8 1923

17 I HEREBY CERTIFY, That I attended deceased from January 7, 1923. to Feby 8, 1923.

that I last saw him alive on Feby 8, 1923.

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. S. McKieffer, M. D.

Feby 9, 1923 (Address) 5320 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Anapolis, Md. Naval Academy Cemtery

DATE OF BURIAL: Feb. 13, 1923.

20 UNDERTAKER: Mrs. J. E. Evans & Sons. 1428

ADDRESS: S. Charles St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 10193

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72276

CERTIFICATE OF DEATH.

R35 D72276

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Kennedy

(a) RESIDENCE NO. 1 Oakwood Terrace Troy N. Y. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Mrs Helen J. Kennedy

6 DATE OF BIRTH (month, day, and year): June 1 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Automobile dealer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Vermont.

PARENTS

10 NAME OF FATHER: John Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Hogan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 FEE 1 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1923, to Feb. 11, 1923,

that I last saw he alive on Feb 11, 1923

and that death occurred, on the date stated above, at 12-35 A.m.

The CAUSE OF DEATH* was as follows:

Uremia. Pyelo-nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 2/6/23

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Reuben G. Bidgood, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Troy New York — DATE OF BURIAL: Feb 11 1923

20 UNDERTAKER: Joseph Abrens — ADDRESS: 220 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

72276 D72277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D72277

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal tuberculosis Hospital ST., 4 WARD)

2-FULL NAME George Carter

(a) RESIDENCE NO. 526 W. Lexington st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Carter

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 DEC 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1922, to Feb. 9, 1923.

that I last saw him alive on Feb. 9, 1923,

and that death occurred, on the date stated above, at 3.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) James L. Padgett, M. D.

2-9-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Iron Cem. Carroll Co. DATE OF BURIAL Feb. 11 1923

20 UNDERTAKER Easton Sons ADDRESS Elkridge Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

12278 D72278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D72278

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 FAIRVIEW AVE. GARDENVILLE. 16 WARD)

2-FULL NAME LAWRENCE VICTOR VOGT

(a) RESIDENCE NO. # 331 FAIRVIEW AVE. GARDENVILLE WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred LIFE yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	INFANT

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) JAN. 22 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	----------	-----	18	

8 OCCUPATION OF DECEASED ----------

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) ----------

(c) Name of employer ----------

9 BIRTHPLACE (city or town) BALTIMORE
(State or country) MARYLAND

PARENTS

10 NAME OF FATHER LEONARD A. VOGT

11 BIRTHPLACE OF FATHER (city or town) BALTO.
(State or country) MARYLAND

12 MAIDEN NAME OF MOTHER ANNA M. DARNEY

13 BIRTHPLACE OF MOTHER (city or town) BALTO.
(State or country) MARYLAND

14 Informant LEONARD A. VOGT
(Address) RASPEBURG MD.

15 Filed FEB 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1923, to Feb. 9, 1923, that I last saw him alive on Feb. 9, 1923, and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. C. Metzel, M. D.

Feb 10 1923 (Address) 1903 W. North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
JERUSALEM CEMETERY

DATE OF BURIAL
FEB. 11 1923

20 UNDERTAKER
Fredk. Lassahn & Sons

ADDRESS
FULLERTON. MD.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

71279
D72279

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72279

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 400 Gold St., St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Belt

(Residence in Baltimore: No. 400 Gold St. St.; 3 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) widower

6-DATE OF BIRTH, About (Month) (Day) 1853 (Year)

7-AGE, 69 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, retired
(b) General nature of Industry, business, or establishment in which employed (or employer), Laborer

9-BIRTHPLACE, (State or Country), Md.

PARENTS:

10-NAME OF FATHER, Robt. Belt

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Doris Krauter

13-BIRTHPLACE OF MOTHER, (State or Country), D.K.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Bankard

(Address) Westminster, Md

15-

Filed FEB 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 10, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Feb. 10 1923 (Address) 2 S. Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Westminster Md — DATE OF BURIAL, Feb 12 1923

20-UNDERTAKER, H Bankard & Son — ADDRESS Westminster Md

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

71 07 7280 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D72280

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 S. Central ave ST., 13 WARD)

2-FULL NAME Giuseppe Pidoto

(a) RESIDENCE NO. 211 S. Central ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 30 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Gaetano Leonardi

6 DATE OF BIRTH (month, day, and year) October 6-1861

7 AGE 61 Years 4 Months 2 Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

050

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Placido Pidoto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosaria Cartabiano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Gaetano Pidoto

(Address) 211 S. Central ave

15 FEB 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8 1923

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1922, to 2-8-, 1923,

that I last saw h[illegible] alive on 2-5, 1923,

and that death occurred, on the date stated above, at 5-8- m.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis
& hypertension.

(duration) ? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. Simarco M. D.

, 19 (Address) 1604 Linden ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 2/12 19 23

20 UNDERTAKER George J. Ruth

ADDRESS 1725 Maryland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72281

CERTIFICATE OF DEATH.

84 D72281

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME Mr. Abraham Harris

(a) RESIDENCE NO. 1824 N. Mount ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Fannie Harris

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Percy Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1409 E. Baltimore St

15 Filed FEB 11 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 9 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1923, to Feb. 9, 1923.

that I last saw him alive on Feb. 9, 1923

and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Post Operative

Pneumonia

(duration) — yrs. — mos 18 ds.

CONTRIBUTORY (Secondary) [redacted] tumor

(duration) — yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 22, 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [redacted] Snyder Jr. Pathologist, M. D.

2/10, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 2/12 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1409 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72282

D72282

REGISTERED NO. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Hebrew Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Ludwig Stern

(a) RESIDENCE NO. 3226 Edgin Ave ST., WARD Phila Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose Stern

6 DATE OF BIRTH (month, day, and year): Nov 28

7 AGE: Years 66 | Months — | Days — | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Social 186

(b) General nature of industry, business, or establishment in which employed (or employer): Service Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Ludwig Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Babett —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Jack Lewis 1439 E Balto St

15 FEB 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Febr. 7th, 1923, to Feb 10th, 1923.

that I last saw him alive on Feb 10th, 19....

and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leonard N Greenbaum M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Cap — DATE OF BURIAL: 2/11 1923

20 UNDERTAKER: Jo Lewis 1439 E Balto St — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Yiddle Sachs. ✓

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72283

CERTIFICATE OF DEATH.

129 D72283

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Aged Home for Chronic ST., 6 WARD)

2-FULL NAME Yiddle Sachs

(a) RESIDENCE NO. 2100 E. Baltimore St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: old aged

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Yiddle Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Katie Roos —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lurie

(Address) 1439 E. Balto St

15 FILED FEB 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/10 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1923, to Feb. 10, 1923,

that I last saw h— alive on Feb. 10, 1923,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chron Nephritis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D.

2/10, 1923 (Address) 210 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL 2/11 1923

20 UNDERTAKER Jack Lurie — ADDRESS 1439 E Balto St

N. B. WHITE PAPER is for information of the Board of Health and is CONFIDENTIAL. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72284

D72284

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 N. Chapel ST.: 6 WARD)

2-FULL NAME Helen Hatcher

(a) RESIDENCE. No. 123 N. Chapel ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 8 Feb. 23

7 AGE — Years: — Months: — Days: 1 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tiss

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Hatcher

11 BIRTHPLACE OF FATHER (city or town) (State or country): U. S.

12 MAIDEN NAME OF MOTHER: Beatrice Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: James Hatcher

(Address): 123 N Chapel

15 Filed FEB 11 1923, 19

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9 Feb. 1923

17 I HEREBY CERTIFY, That I attended deceased from 8 Feb., 1923, to 9 Feb., 1923, that I last saw h[illegible] alive on 9 Feb., 1923, and that death occurred, on the date stated above, at about 5 30 p.m.

The CAUSE OF DEATH* was as follows:

Loss of vitality.

(duration) ___ yrs. ___ mos. 1 ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. Field Dayd, M. D.

2-7-1923 (Address) 1128 N. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: at Burg Cemetery

DATE OF BURIAL: Feb 11 1923

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 [illegible] Orleans St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pneumonia

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72285

CERTIFICATE OF DEATH.

D72285

100-001

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Rutland Ave, ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hughes jr

(Residence in Baltimore: No. 911 Rutland Ave St.; 2 yrs., 8 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June (Month) 6 (Day), 1920 (Year)

7-AGE, 2 yrs. 8 mos. 3 ds.

If LESS than 1 day, ...hrs. or ....mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER. William Hughes

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Estella Turner

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Hughes

(Address) 911 Rutland Ave

15-

FEB 11 1923 191 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 9 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 8 1923, to Feb. 9 1923, that I saw him alive on Feb. 9 1923, and that death occurred, on the date stated above, at 6.35 p. m.

The CAUSE OF DEATH* was as follows:

a Bronchial Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ....yrs. ....mos. one ds.

(Signed) W. C. Sandrock M. D.

Feb. 10, 1923. (Address) 1242 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Bury cemetery

DATE OF BURIAL, Feb 12, 1923.

20-UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

A. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate. classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72286

D72286

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 632 Madeira ST.: 7 WARD)

2-FULL NAME Levi Hutchens

(a) RESIDENCE. No. 632 Madeira ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Malinder Hutchens

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Ann Co Maryland

PARENTS

10 NAME OF FATHER Jerves Hutchens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Henrietta Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Leaviana Conway
(Address) 632 Madeira St

15 FEB 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8 1923

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1923, to Feb 8, 1923, that I last saw him alive on Feb 7, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Gastritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Stricture of the Oesophagus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. E. Thomas, M. D.

2-9-1923 (Address) 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arbutus cemetery	Feb 11 1923
20 UNDERTAKER	ADDRESS
Edward Bryon	1631 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

(Approved by U. S. Census and American Public Health Asso.)

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cancer of Stomach

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72287

CERTIFICATE OF DEATH.

31

D72287

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 McCulloh ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maud Atkinson

(Residence in Baltimore: No. 1619 McCulloh St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Nov. 11th, 1889
(Month) (Day) (Year)

7-AGE, 33 yrs. 2 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): Private

9-BIRTHPLACE. (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, Thomas B. Pearson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliz. Pearson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George S. Atkinson

(Address) 1619 McCulloh St

FEB 11 1923

Filed ....., 191. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 7th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 12th 1922 to Feb. 7th 1923, that I saw her alive on Feb. 7th 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Possibly Syphilis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Lee Chew M. D.

Feb 8, 1923 (Address) 724 Mondawmin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Jos. D. Auburn Cem. DATE OF BURIAL. Feb 11, 1923

20-UNDERTAKER George H. Holland ADDRESS 763 Darling Ave

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72288 100-00 D72288

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 523 N. Ellwood ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Roberts

(Residence in Baltimore: No. 523 N. Ellwood ave St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 5, 1914
(Month) (Day) (Year)

7-AGE, 8 yrs. 8 mos. 4 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James E. Roberts

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lillian G. Daniels

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James E. Roberts

(Address) 523 N. Ellwood ave

15- FEB 11 1923 Filed....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 9th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 9 1923, to Feb 9th 1923, that I saw him alive on Feb 9th 1923, and that death occurred, on the date stated above, at 12m p.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) 0

(Duration) ....yrs. ....mos. ....ds.

(Signed) Adams Tod M. D.

....., 191... (Address) 4704 Eastern ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Feb 12, 1923

20-UNDERTAKER Henry Lutz

ADDRESS 1203 N. Broadway

REGISTERED. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72289 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D72289

CERTIFICATE OF DEATH. 90 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1401 Edmondson Ave St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss N. Whelan

(Residence in Baltimore: No. 1419 N Carey St. 45 St.; yrs. ~~5~~ mos. ~~2~~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Fem'l	white	Single

6-DATE OF BIRTH. Dec. 7 (Month) (Day) 1877 (Year)

7-AGE. 45 yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... saleswoman
(b) General nature of industry, business, or establishment in which employed (or employer)..... Flour

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Jas. Whelan

11-BIRTHPLACE OF FATHER. (State or Country). Canada

12-MAIDEN NAME OF MOTHER. Laura Hogue

13-BIRTHPLACE OF MOTHER. (State or Country). City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss N. Whelan

(Address) 4017 Belview Ave

15- FEB 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk.
Filed ..... 192 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb. 9 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pyaemia Heart disease

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. J. Heenan, M. D. (Coroner.)

Feb. 10 1923 (Address) 285 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. London Park DATE OF BURIAL. FEB 12 1923 19...

20-UNDERTAKER. Geo W Little ADDRESS ~~Edmondson Ave~~ ~~Baltimore, Md.~~

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72290

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D72290

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 Calhoun ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Ennis

(a) RESIDENCE NO. 1101 Calhoun ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Ennis

6 DATE OF BIRTH (month, day, and year) Mar 22, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) N/A

(c) Name of employer

9 BIRTHPLACE (city or town) West River (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Ennis

11 BIRTHPLACE OF FATHER (city or town) West River (State or country) Md

12 MAIDEN NAME OF MOTHER Nancy Simms

13 BIRTHPLACE OF MOTHER (city or town) West River (State or country) Md.

14 Informant Carrie Ennis

(Address) 1101 Calhoun St

15 FEB 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923, to Feb 9, 1923, that I last saw him alive on Feb 8, 1923 and that death occurred, on the date stated above, at 9.40 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. William Frey, M. D.

2/9, 1923 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL 2/12 1923

20 UNDERTAKER Franklin H Seitz

ADDRESS 709 N 33rd St

N. B.—WHEN BLANKS, WHICH CANNOT BE FILLED, ARE LEFT IN THIS CERTIFICATE, THE REGISTRAR WILL RETURN IT FOR INFORMATION. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160437 D72291 X 49 D72291

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) ..... ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Pritchett

(a) RESIDENCE NO. Ottoman, Va. ST., ... WARD Ottoman Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13, 1860

7 AGE — Years: 62 — Months: 10 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Thomas Pritchett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Sacrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address)

15 FEB 11 1923 Filed, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922, to Feb 10, 1923, that I last saw him alive on Feb 10, 1923, and that death occurred, on the date stated above, at 1.50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene C. Shaw, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Millenbeck Va.

DATE OF BURIAL: Feb 11 1923

20 UNDERTAKER: N M Routson

ADDRESS: 2208 N Avenue

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72292 11-001 D72292

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Woodley st ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred B Coley

(Residence in Baltimore: No. 1017 Woodley st St.; 25 yrs., 3 mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	W	Married

6-DATE OF BIRTH, May (Month) 17 (Day), 1852 (Year)

7-AGE, 70 yrs. 8 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Collector
(b) General nature of Industry, business, or establishment in which employed (or employer): n/a

9-BIRTHPLACE, (State or Country), U.S. (Unknown)

PARENTS.

10-NAME OF FATHER, Benjamin Coley

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Miss Taves

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lillian E Coley

(Address) 1017 Woodley St

15- Filed FEB 11 1923 ROBERT R. KRAUTER, Register.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 9 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 7 23 1923, to Feb 9 23 1923, that I saw him alive on Feb 9-23 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Catarrhal Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) La Grippe (?)

(Duration) ....yrs. ....mos. 2 weeks ds.

(Signed) A W Gaddes M. D.

2/9/23, 191... (Address) 321 E 25

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, Feb. 12, 1923

20-UNDERTAKER H. M. Renton — ADDRESS 2258 W North

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72293 D72293

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 W Mulberry ST., 4 WARD)

2-FULL NAME Joseph D Keenan

(a) RESIDENCE No. 421 W Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 88 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary J Keenan

6 DATE OF BIRTH (month, day, and year): Aug 21 3x

7 AGE — Years: 88 — Months: 5 — Days: 13 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Morrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Mrs Mary A Lucas

(Address): 225 N Woodberry

15 Filed FEB 11 1923, 19 ... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1922, to Feb 7th, 1923, that I last saw him alive on Feb 7th, 1923, and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Apoplexy

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank W Gamon, M. D.

Feb 19 (Address) 322 N Greene

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Feb 12 1923

20 UNDERTAKER: N McCoulson — ADDRESS: 2235 N Charles

N. B. WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. LEAVE NO BLANKS. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72294

D72294

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Orleans ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Schmelz

(a) RESIDENCE. NO. 1109 Orleans ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced (or) WIFE of Geo. H. Schmelz

6 DATE OF BIRTH (month, day, and year) Feb 10 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Geo H Schmelz

(Address) 1109 Orleans

15 FEB 11 1923 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1923, to Feb. 10, 1923, that I last saw h.er alive on Feb. 9, 1923, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Henry Boyle, M. D.

Feb. 10, 1923 (Address) 602 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	2/13 1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See Letter over) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72295

CERTIFICATE OF DEATH.

49

D72295

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) ~~Emma~~ Bon Secours Hospital ST. 12 WARD)

2-FULL NAME Emma K Livingston

(a) RESIDENCE NO. 1635 K Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Edw L Livingston

6 DATE OF BIRTH (month, day, and year) Feb 1. 1880 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46.	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) York (State or country) Pa

PARENTS

10 NAME OF FATHER Jacob Yeager

11 BIRTHPLACE OF FATHER (city or town) York (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah A Jeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Sadie Henkel

(Address) 7 N Bentalou

15 FEB 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1923

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1922, to Feb 9, 1923,

that I last saw her alive on " , 1923.

and that death occurred, on the date stated above, at 4 A m

The CAUSE OF DEATH* was as follows:

Hypernephroma (left kidney)

Chr. Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw. A. Cockrane M. D.

2/10 1923 (Address) 24 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 2/13 1923

20 UNDERTAKER Lee Cook — ADDRESS 502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72296

CERTIFICATE OF DEATH.

46 D72296

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca McNew

(a) RESIDENCE No. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) July 16 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	44	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 FEB 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from August 8, 1922, to February 9, 1923, that I last saw her alive on February 9, 1923, and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) [illegible] M. D.

2-10-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wk Carnegie — DATE OF BURIAL 2/13 1923

20 UNDERTAKER Tom Cook — ADDRESS 502 E North

NOTE—WRITE plainly with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DR. EDWARD V. COOLAHAN
BALTIMORE, MD.

February 27, 1923.

Dr. C. Hampson Jones,
Health Department,
Baltimore, Md.

Dear Dr. Jones:

I am in receipt of a letter from Mr. John J. Pratt, attorney to the estate of the late Emma M. Livingston, who advises me that the age on the death certificate recorded in the Health Department is not correct.

The record should read: Date of birth, February 1, 1877, making the age at the time of death 46 years, 10 days. This information is recorded in the family bible.

Kindly make necessary changes in her certificate.

Very truly yours,

Edward V. Coolahan

EVC/MCK.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72297

CERTIFICATE OF DEATH.

90 D72297

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6201 Carey St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G Clarke Jr

(a) RESIDENCE No. 620 N Carey St., Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs 3 mos 2 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 4th 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John G Clarke Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ella Clark Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mr John G Clarke 620 N Carey St.

15 FEB 11 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1923

17 I HEREBY CERTIFY, That I attended deceased from January 30, 1923, to Feb 8, 1923, that I last saw him alive on Feb 7, 1923, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Failure of Compensation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) I Walter Stamos, M. D.

Feb 10 1923 (Address) 1228 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Cathedral Cemetery	Feb 12th 1923

20 UNDERTAKER	ADDRESS
H. C. Brauning & Son	57 N Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D72298

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. [illegible] WARD)

2-FULL NAME. James Fahey

(a) RESIDENCE. No. Mt Hope Retreat ST. 28 WARD. Balto Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	34	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): Clerking. 09

(c) Name of employer: (?)

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Michael Fahey

11 BIRTHPLACE OF FATHER (city or town) (State or country): (?) Ireland

12 MAIDEN NAME OF MOTHER: Mary Larkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): (?) Ireland

14 Informant (Address): Records of Mt Hope Retreat Mount Hope Balto Md.

15 Filed FEB 11 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10th 1923

17

I HEREBY CERTIFY, That I attended deceased from Mch 8th, 1917, to Feb 10th, 1923, that I last saw h[illegible] alive on Feb 9th, 1923, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Epilepsy.

abt 6 or 7 years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mania Epileptic.

abt (duration) 6 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Feb 10, 1923 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral

DATE OF BURIAL: Feb 12th 1923

20 UNDERTAKER: J. C. Brauning & Son

ADDRESS: 571 N. Schroeder St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72299

CERTIFICATE OF DEATH.

100-001 D72299

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2041 W. North Ave. ST., 15 WARD)

2-FULL NAME Sarah C. Morton

(a) RESIDENCE No. 2041 W. North Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hollowell Maine
(State or country)

PARENTS

10 NAME OF FATHER Philander Morton

11 BIRTHPLACE OF FATHER (city or town) Maine
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mr. Stockbridge
(Address) 2041 W. North Ave

15 Filed FEB 11 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1923

17 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h... alive on ....., 19.....
and that death occurred, on the date stated above, at 2.30 P m.
The CAUSE OF DEATH* was as follows:

.....(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ....., M. D.

....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 2/12 1923

20 UNDERTAKER Wm. M. Gawthrop

ADDRESS 1839 Ray

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72300 D72300

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 Jackson ST., 24 WARD)

2-FULL NAME Georgiana Reynolds

(a) RESIDENCE NO. 1823 Jackson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. / mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Frank Reynolds

6 DATE OF BIRTH (month, day, and year) ——— 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	73	+	+	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co. (State or country) Maryland.

PARENTS

10 NAME OF FATHER Joseph Lydia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Bitzenberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Pinkney & Ecrstein

(Address) 1823 Jackson St.

15 Filed FEB 11 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb, 10 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan, 23, 1923 to Feb, 10, 1923.

that I last saw her alive on Feb, 9, 1923,

and that death occurred, on the date stated above, at 7.50 a.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia, chronic myocarditis, chronic interstitial nephritis

(1 week) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of left hip

(2 1/2 yrs ago) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Hospital conf. + aut.

(Signed) David Franklin M. D.

2/10 1923 (Address) 1211 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pk Cem	2/12 1923
20 UNDERTAKER	ADDRESS
J. Fenw McCully	130 E. Fort

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental fall down steps
2½ years ago.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72301

CERTIFICATE OF DEATH.

100-001

D72301

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3426 Chestnut Ave. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman H. Abbott

(Residence in Baltimore: No. 3426 Chestnut Ave. St.: 1 yrs., 7 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, June (Month) 25 (Day), 1921 (Year)

7-AGE, 1 yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Hugh C. Abbott

11-BIRTHPLACE OF FATHER (State or Country), Carroll Co. Md.

12-MAIDEN NAME OF MOTHER Edith M. Younger

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hugh C. Abbott

(Address) 3426 Chestnut Ave

15-

Filed FEB 11 1923, ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 10 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 7 1923, to Feb 10 1923, that I saw him alive on Feb. 9 1923, and that death occurred, on the date stated above, at 6.55 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) ....yrs. ....mos. ½ ds.

(Signed) ..... M. D.

Feb 10, 1923 (Address) 3426 Chestnut Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys (Hampden) DATE OF BURIAL, Feb 12, 1923

20-UNDERTAKER Horace A. Burgee ADDRESS 3631 Falls Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D72302

CERTIFICATE OF DEATH.

90 D72302

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 Hanover St. ST. 43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Kern.

(a) RESIDENCE NO. 1302 Hanover St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 11 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

5a If married, widowed, ~~or divorced~~ ~~HUSBAND OF WIFE OF~~ Lena Kern.

6 DATE OF BIRTH (month, day, and year) Feb, 22, 1845.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	77	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Can maker. 6 8

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John C. Kern.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Margaret Schumacher.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Tillie Schloman. (daughter)

(Address) 1302 Hanover St.

15 FEB 11 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb, 9th. 1923

17 I HEREBY CERTIFY, That I attended deceased from January 15th 1923, to February 9, 1923.

that I last saw him alive on February 3, 1923

and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ---------

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical diagnosis.

(Signed) Otto M. Einhardt, M. D.

2/9/23. 19 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Feb. 12 1923

20 UNDERTAKER: E. Schloman & Son

ADDRESS: 603 Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. D52303

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2417 Barcaly ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Richter

(Residence in Baltimore: No. 2417 Barcaly St. 50 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.): Married

6-DATE OF BIRTH, Sept 23, 1862
(Month) (Day) (Year)

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Auto Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer): Gaeth Spring Works

9-BIRTHPLACE. (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Don't Know

11-BIRTHPLACE OF FATHER (State or Country): Don't Know

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm F Richter
(Address) 2417 Barcaly

15- FEB 11 1923 Filed, 191.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 10, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Valvular disease of heart
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) John H. Kemmler M. D.
(Coroner.)
1923 (Address) 2432 Boland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt Carmel — DATE OF BURIAL, 2/14, 1923

20-UNDERTAKER Wm Cook — ADDRESS 502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH INDELIBLE PENCIL OR PEN AND INK. PHYSICIANS should state carefully and fully all information called for. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

S. Arthur Pub. Book & Lumber Co.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72304

CERTIFICATE OF DEATH.

90 D72304

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 So. Clinton ST., 16 WARD)

2-FULL NAME Margaret Fell

(a) RESIDENCE NO. 102 S. Clinton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Fell

6 DATE OF BIRTH (month, day, and year) Dec 4 1831

7 AGE Years 92 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mrs. E. K. Schapman

(Address) 102 S. Clinton

FEB 11 1923 Filed ....., 19.....

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1 1921 to Feby 9 1923.

that I last saw him alive on Feby 7 1923

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Valvular Disease Heart

(duration) 1 yrs. 10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edel K Utley M. D.

Feby 1923 (Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Vendor Park

DATE OF BURIAL Feb 12 1923

20 UNDERTAKER H. M. Cook

ADDRESS 502 E. N. Ave

Spec.--1-10-21--M&T--1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72305 D72305

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 519 N: Wolfe St. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amalia Mohlhenrich

(a) RESIDENCE NO. 519 N: Wolfe St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Mohlhenrich

6 DATE OF BIRTH (month, day, and year) June 8th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	8	I	

8 OCCUPATION OF DECEASED at home

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Bernhard Werner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Zeilein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Moelhenrich

(Address) 519 N: Wolfe St

15 FEB 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1920 to Feb 10 1923,

that I last saw her alive on Feb 9th 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis; Diabetes

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings, Lab. Tests.

(Signed) Michael A. Adams, M. D.

Feb 11 1923 (Address) 1300 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery

DATE OF BURIAL Feb 13 23

20 UNDERTAKER John Sellers

ADDRESS 200 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72306

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72306

38

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 Cathedral ST., 11 WARD)

2-FULL NAME John Charles Green

(a) RESIDENCE NO. 1029 Cathedral St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Sin

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3 1923

7 AGE — Years: — Months: 1 Days: 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Jas W. Green

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Effie V. Alushire

13 BIRTHPLACE OF MOTHER (city or town) Luray (State or country) Va.

14 Informant (Address) Mrs E V. Green (mother) 1029 Cathedral

15 Filed FEB 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1923

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1923, to Feb. 10, 1923, that I last saw h alive on Feb. 10, 1923, and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann + from mother

(Signed) Frances L. Krauch, M. D.

, 19 (Address) 16 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: 2/12/23

20 UNDERTAKER: Engel & Farley

ADDRESS: Fulton & Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 72307

Spec.—1-10-21—M&T—1500 Bks.

72307

D 72307

72307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

139

D72307

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Burrows

(a) RESIDENCE NO. 215 Central Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eddie Burrows

6 DATE OF BIRTH (month, day, and year): Dec 22 1880

7 AGE: Years 42 | Months 1 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Pauline Burrows

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant Jackson Burrows

(Address) 918 36 Ave Ens Co

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 25 1923 to Feb 6 1923

that I last saw her alive on Feb 6 1923

and that death occurred, on the date stated above, at 7.05 P. m.

The CAUSE OF DEATH was as follows: Uremic Febroids

over

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. 7 mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Feb 8, 23

Was there an autopsy? No.

What test confirmed diagnosis? Surgical operation

(Signed) A. [illegible] M. D.

....., 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Cemetery — DATE OF BURIAL: Feb 13th 1923

20 UNDERTAKER: Milton Davis — ADDRESS: 315 N Eden St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. D 72308

161470 72308

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

72308 D72308

101-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. 1 ST., 5 WARD)

2-FULL NAME Charles Smith

(a) RESIDENCE NO. 16 N. Dallas St ST., D WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mary Land

12 MAIDEN NAME OF MOTHER Emma Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL. Record
(Address)

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1923, to Feb 10, 1923, that I last saw him alive on Feb 10, 1923 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

8
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumococcus Meningitis 2 d (1)
(duration) yrs. mos.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Horton Caspara M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arbury Cemetery	Feb 11th 1923
20 UNDERTAKER	ADDRESS
Milton Dana	316 N Eden St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

72309 HEALTH DEPARTMENT—CITY OF BALTIMORE D 72309

CERTIFICATE OF DEATH.

X 44

1-PLACE OF DEATH D72309 REGISTERED NO. D72309

CITY OF BALTIMORE: (No. 1525 Bolton, St., Balto. Md. WARD 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elliott M. Peck Jr.

(a) RESIDENCE. NO. Pine Orchard, Conn. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 5 1918

7 AGE: Years 4 Months 10 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) New Haven Conn

PARENTS

10 NAME OF FATHER Elliott M Peck

11 BIRTHPLACE OF FATHER (city or town) New Haven (State or country) Conn

12 MAIDEN NAME OF MOTHER Marguerite Harris

13 BIRTHPLACE OF MOTHER (city or town) New Haven (State or country) Conn

14 Informant Marguerite Peck
(Address) New Haven Conn

15 Filed FEB 12 1923 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1923, to Feb. 11th, 1923, that I last saw h[illegible] alive on Feb 11th, 1923, and that death occurred, on the date stated above, at 2.55 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Liver

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan 3rd 1923

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) Guy U. Cromwell M. D.

2/11, 1923 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Haven Conn DATE OF BURIAL: Feby 12 1923

20 UNDERTAKER: Wm Isherwood Sons ADDRESS: Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Delphine Emmert

72310 HEALTH DEPARTMENT—CITY OF BALTIMORE 72310

D72310 CERTIFICATE OF DEATH. D72310

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. 885 W. Fayette St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Delphine Emmert.

(Residence in Baltimore: No. 885 W. Fayette St. 18 St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1..... (Year)

7-AGE, 75 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nom.
(b) General nature of industry, business, or establishment in which employed (or employer): 50

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): " "

12-MAIDEN NAME OF MOTHER: " "

13-BIRTHPLACE OF MOTHER, (State or Country): " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt Brooks

(Address) Calhoun & Hollins

15 FEB 12 1923 ROBERT R. KRAMER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 8 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (~~Inquest, autopsy~~ or Inquiry.) thereon and from the evidence obtained by said ..... ~~Inquest, au-~~ ..... ~~topsy or~~ Inquiry.) find that said deceased came to h.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) ..... yrs. dont Know mos. ..... ds.

CONTRIBUTORY (Secondary) dont Know

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch M. D. (Coroner.)

2-11-1923 (Address) 117 W Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Greenmount Cem. DATE OF BURIAL: 2/12/23

20-UNDERTAKER: Robt Brooks & Son ADDRESS: Calhoun & Hollins

(Rev. 1922) Physician or other person in charge of case must fill out and sign this certificate. Undertaker must fill out and sign this certificate. Information should be furnished by relatives or friends of deceased. Every question must be answered, and if the information required is not known, that fact must be stated. Name of deceased must be supplied. Cause of death must be properly classified. Exact statement of OCCUPATION and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72311

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (Street) (WARD)

2-FULL NAME George John Pirie

(a) RESIDENCE No. 3024 Brighton ST., WARD 10

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred all life ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Ida Neal Pirie

6 DATE OF BIRTH (month, day, and year) May 11, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Robt. Padgett Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Harry J. Pirie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Isabella McCoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Hospital Records (Address)

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1923, to Feb. 9, 1923, that I last saw him alive on Feb. 9, 1923, and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Respiratory Paralysis

(duration) Partial mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Symptoms & Signs.

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Feb 12 1923

20 UNDERTAKER Martin Fahey & Son — ADDRESS 1021 W North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72312

CERTIFICATE OF DEATH.

100-00

D72312

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1402 Brunt St. ST. 14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Pinder

(Residence in Baltimore: No. 1402 Brunt St. St.; yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	colored	Single

6-DATE OF BIRTH. March 10, 1922
(Month) (Day) (Year)

7-AGE. ....yrs. 11 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER Elisha Pinder

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Elizabeth Compton

13-BIRTHPLACE OF MOTHER (State or Country), Prince George Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Pinder

(Address) 1402 Brunt St.

15- FEB 12 1923 ROBERT R. KRAMER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 10, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and from other sources find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Feb. 11, 1923 (Address) 2 E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carroon Cem

DATE OF BURIAL, 2-12-1923

20-UNDERTAKER Daniel Carter

ADDRESS 916 Pa ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16403 Page D72313

CERTIFICATE OF DEATH.

100-001 D72313

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No.) ST., 14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Smith

(a) RESIDENCE NO. 509 N. Bruce St ST., WARD 14

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 16 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 17 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Bands

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL Records

(Address)

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1923, to Feb 8, 1923, that I last saw him alive on Feb 8, 1923, and that death occurred, on the date stated above, at 7:15 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (primary)

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Mead, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 2-12-1923

20 UNDERTAKER Harriet Eastern

ADDRESS 918 Fenna ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72314

CERTIFICATE OF DEATH.

31 D72314

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Mosher St., 16 Ward)

2-FULL NAME John H. Henderson

(a) RESIDENCE NO. 1628 Mosher St., 16 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or WIFE of: Susie Henderson

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 43; Months; Days; If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't Know

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant: Daniel Easton

(Address) 916 Pa ave

15 ROBERT L. KRAUTER, Burial Permit Clerk. Registrar

. 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1923, to Feb 9, 1923, that I last saw h alive on Feb 8, 1923 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

Tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Carl Brown, M. D.

2/12, 1923 (Address) 1837 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 2-12 1923

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Pa ave

FEB 12 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72315

1PLACE OF DEATH

CERTIFICATE OF DEATH.

1917 — D72315

REGISTERED No. C

CITY OF BALTIMORE (No. Foot of Philpot St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Joseph Dobrowski

(Residence in Baltimore: No. 1571 Aliceanna St. St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH: March (Month) 19 (Day), 1900 (Year)

7-AGE: 22 yrs. 11 mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 140

9-BIRTHPLACE (State or Country): Balt

PARENTS.

10-NAME OF FATHER: Thomas Dobrowski

11-BIRTHPLACE OF FATHER (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Carrie Ruschmka

13-BIRTHPLACE OF MOTHER (State or Country): Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Dobrowski

(Address) 1571 Aliceanna St

15- FEB 12 1923 ROBERT B. KNAUER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: February (Month) 8 (Day), 1913. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by the Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Fell over board

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. B. Horton (Coroner) M. D.

Feb 10 1923 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. Factor Mill

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Cross — DATE OF BURIAL: Feb. 12, 1923

20-UNDERTAKER: Randall Appel & Son — ADDRESS: 318 N

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72316

CERTIFICATE OF DEATH.

31 D72316

1-PLACE OF DEATH

REGISTERED NO. 16 1071

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 1716 Riggs Ave ST. WARD

2-FULL NAME Lee Morris

(a) RESIDENCE. No. 1716 Riggs Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 2, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Middlesex County Va.

PARENTS

10 NAME OF FATHER Samuel Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Matilda Ruffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Matilda Morris

(Address) 1716 Riggs Ave

15 Filed FEB 12 1923 19 ROBERT R. PRALL Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1923, to Feb. 10, 1923, that I last saw h[illegible] alive on Feb. 10, 1923, and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Biopsy & Sputum.

(Signed) John D. Dickerson, M. D.

(Address) 1507 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
mt auburn Cemetery	Feb 12 19
20 UNDERTAKER	ADDRESS
Joseph A Farrell	2319 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 72317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72317

D72317

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 1st WARD) 14

2-FULL NAME Calvin Jones

(a) RESIDENCE NO. 1821 Bryant St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 4-'922

7 AGE: Years — Months: 8 — Days: 4 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Lee Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ida Boone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Records

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to Feb 8, 1923, that I last saw him alive on Feb 8 - 1923, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. 1 mos 5 ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? no Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy

(Signed) R. H. Mead, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt auburn cemetery

DATE OF BURIAL: Feb. 1923

20 UNDERTAKER: Joseph A. Farrell

ADDRESS: 2319 Division

1. WRITE plainly and carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72318

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. John Hopkins Hosp St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lelia Emma

(Residence in Baltimore: No. 1202 N. Wolfe St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Black	~~Single~~ Widowed

6-DATE OF BIRTH, Feb 8, 1923
(Month) (Day) (Year)

7-AGE, ...yrs....mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Emma

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Lelia Price

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lelia Emma

(Address) 1202 N Wolfe

15-

FEB 12 1923 191 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 9, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took ~~charge~~ of the remains described above, held an autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said autopsy
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Bowels.

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Haemophilia

(Duration) ....yrs....mos....ds.

(Signed) J. S. Emma M. D.
(Coroner.)

2-10 1923 (Address) 506 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Feb 13, 1923

20-UNDERTAKER Wm Robert Arthur — ADDRESS 725 Oakland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Mildred M Dey)

D72319

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72319

CERTIFICATE OF DEATH.

10

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 25 Mattfelat ~~Ave~~ St. 71 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mildred M. Dey

(Residence in Baltimore: No. 25 Mattfelat Ave (or Road) ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX F.

4 COLOR OR RACE White

5 SINGLE, ~~MARRIED, WIDOWED, or DIVORCED~~ (Write the word) Sing

6 DATE OF BIRTH July 15, 1916 (Month) (Day) (Year)

7 AGE 6 yrs. 6 mos. 26 ds. If LESS than 1 day, ... hrs. or ... mln.

8 OCCUPATION
(a) Trade, profession, or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9 BIRTHPLACE (State or Country) Md.

PARENTS.

10 NAME OF FATHER Bernard F. Dey

11 BIRTHPLACE OF FATHER (State or Country) Germany

12 MAIDEN NAME OF MOTHER Maud N. Beard

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maud M. Dey

(Address) 25 Mattfelat Ave

FEB 12 1923 Filed ..., 191... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. (Month) 10 (Day) , 1923 (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and from Dr. Hart and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos Morrissey M. D. (Coroner) Feb 11 1923 (Address) 432 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, OR REMOVAL Woodlawn Cem | DATE OF BURIAL Feb. 12, 1923

20 UNDERTAKER Chenoweth & Son | ADDRESS Chestnut Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72320

CERTIFICATE OF DEATH.

90

D72320

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 S. Smallwood ST., 10 WARD)

2-FULL NAME Caroline Hoffman NO

(a) RESIDENCE NO. 425 S. Smallwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Hoffman

6 DATE OF BIRTH (month, day, and year): June 22 1847

7 AGE: Years 75 | Months | Days 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Edna Norton

(Address) 4435 S. Smallwood

15 FEB 12 1923 Filed, 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 10 1923

17 I HEREBY CERTIFY, That I attended deceased from February 3, 1923, to February 10, 1923.

that I last saw h alive on February 10, 1923.

and that death occurred, on the date stated above, at 1215 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis. Arteriosclerosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema, (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norval C. Mitch, M. D.

2/11, 1923 (Address) 2151 Bulkman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: 2/13 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72321

CERTIFICATE OF DEATH.

D72321

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD) 10

REGISTERED NO. 125

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Coyne

(a) RESIDENCE NO. 79 3rd ave - Wagner's Pt. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 10- 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) md.

PARENTS

10 NAME OF FATHER William Coyne

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md

12 MAIDEN NAME OF MOTHER Elizabeth groskopf 2/12/23

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) md

14 Informant Wm Coyne

(Address) 79 3rd Ave. Wagner's Pt.

15 FEB 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 — 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1923, to Feb 10, 1923, that I last saw living on Feb 10, 1923, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) B.B. MacLaurin, M. D.

(Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem | DATE OF BURIAL 2-12-1923

20 UNDERTAKER E & B Hahn | ADDRESS 115 E Ross

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D72322

CERTIFICATE OF DEATH.

D72322

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1510 b Eliftview Ave St.. WARD) 8

2-FULL NAME Elizabeth Ritterbusch

(a) RESIDENCE NO. 1510 b Eliftview Ave St.. WARD 8

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 25 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md,

PARENTS

10 NAME OF FATHER Henry Ritterbusch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louise Robinson (Address) 1510 b Eliftview

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1923, to Feb 10, 1923, that I last saw h w alive on Feb 10, 1923 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? No

(Signed) J. Fisher M. D.

2/11, 1923 (Address) 1823 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenly Cemetery DATE OF BURIAL Feb 13 1923

20 UNDERTAKER Robt J Turner Inc ADDRESS 1444 Broadway

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72323 HEALTH DEPARTMENT—CITY OF BALTIMORE D72323

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 5009 Tioga Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar Hess

(Residence in Baltimore: No. 5009 Tioga St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Sept 20 1885
(Month) (Day) (Year)

7-AGE. 37 yrs. 4 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Printing Pressman
(b) General nature of industry, business, or establishment in which employed (or employer): Operator 8th

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Isaac Hess

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary A Miller

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Florence Simon

(Address) 5009 Tioga Ave

FEB 12 1923
Filed ... 192...

ROBERT H. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 9 192.3
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) John C Allen M. D.
(Coroner.)

2-11 1923 (Address) 5008 E North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Parkwood	Feb 12 1923
20-UNDERTAKER. Burkler & Burkler	ADDRESS 1739 Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79824

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

74-001

D72324

REGISTERED NO.

CITY OF BALTIMORE: (No. 829 Leadenhall ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Emerson James

(a) RESIDENCE. No. 829 Leadenhall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Agnes

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Ellen James (Address) 829 Leadenhall St

15 Filed [illegible] ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/9/ 19 23

17 I HEREBY CERTIFY, That I attended deceased from 1/29/ 19 23, to 2/8/ 19 23, that I last saw h[illegible] alive on 2/8/ 19 23, and that death occurred, on the date stated above, at 10.20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Subacute Pancreatitis - Diabetes Mellitus

(duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopical - Urine

(Signed) J. Emory Morley, M. D.

2/10/ 19 23 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Ct — DATE OF BURIAL: Feb 12 19 23

20 UNDERTAKER: A. L. Brown's Son — ADDRESS: 1086 Monty

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72325

11-001

CERTIFICATE OF DEATH.

D72325

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 W Franklin ST., 10 WARD)

2-FULL NAME Arthur Bernard Johnson

(a) RESIDENCE NO. 17 N. Fremont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3 1922

7 AGE: Years 7 Months 5 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Alfred Johnson

11 BIRTHPLACE OF FATHER (city or town) D C
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Spears

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. Johnson

(Address) 1712 W Franklin St.

15 FEB 12 1923 Filed, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Made ave 19 Visit, 19

that I last saw him alive on Feb 12, 19 23

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. D ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James M Hooper, M. D.

, 19 (Address) 1210 Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Feb 12 1923

20 UNDERTAKER: Edward Bryan

ADDRESS: 1631 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72326

CERTIFICATE OF DEATH.

90 D72326

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2213 W Baltimore St. 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert L. Krauss

(Residence in Baltimore: No. 2213 W Baltimore St.; yrs. 39 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced (Write the word.): Married

6-DATE OF BIRTH: April (Month) 23 (Day) 1883 (Year)

7-AGE: 39 yrs. 9 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): machinist

9-BIRTHPLACE, (State or Country): Baltimore City

PARENTS.

10-NAME OF FATHER: Wm F Krauss

11-BIRTHPLACE OF FATHER, (State or Country): Balt City

12-MAIDEN NAME OF MOTHER: Catherine E Jeanrod

13-BIRTHPLACE OF MOTHER, (State or Country): Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine E. Krauss

(Address) 2213 W Balt St.

15-

FEB 12 1923

Filed ..... ROBERT K. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 9 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry) find that said deceased came to Dea death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) acute Dilatation of heart (Duration) 2 yrs. ....mos. ....ds.

(Signed) James M Fanton M. D. (Coroner.)

Feb 9 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Druid Ridge DATE OF BURIAL, July 12, 1923

20-UNDERTAKER. J. O. Mitchell ADDRESS 1001 W. Fayette St.

INSTRUCTIONS.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72327

CERTIFICATE OF DEATH.

D72327

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hosp St. 6 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur Williams

(Residence in Baltimore: No. 3 N. Castle St St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	

6-DATE OF BIRTH. Aug 25 1921
(Month) (Day) (Year)

7-AGE. yrs. 5 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Arthur Williams

11-BIRTHPLACE OF FATHER. (State or Country). South Carolina

12-MAIDEN NAME OF MOTHER. Lillian Alston

13-BIRTHPLACE OF MOTHER. (State or Country). South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hopkins Hosp

(Address)

15- FEB 12 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb 9 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Trauma

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pertussis

(Duration) yrs. mos. ds.

(Signed) J. H. Kolle M. D.
(Coroner.)

Feb 9 1923 (Address) 1218 E. Lafayette

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. JOHNS HOPKINS HOSPITAL DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS FEB 10 1923

Commissioner Health.

In case of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D72328

CERTIFICATE OF DEATH.

1-PLACE OF DEATH D72328

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Trott

(a) RESIDENCE NO. University Hospital ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 7, 1923

7 AGE — Years — Months — Days — If LESS than 1 day, 1 hrs. or 53 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Morris Trott

11 BIRTHPLACE OF FATHER (city or town) Anne Arundel Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Elizabeth Kirby

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel Co (State or country) Maryland

14 Informant Brother D Morton

(Address) .....

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923, to Feb 7, 1923, that I last saw him alive on Feb 7, 1923, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Premature

1 30 Mest

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Feb 7 1923 Caesarean Section for mother

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) J. Norwood Wilson M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner Health. — ADDRESS: FEB 10 1923

Mar. Wm. H. WOOBALL

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72329

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72329 38 D72329

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat (St.:) 28 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Kowolski

(a) RESIDENCE. No. Mt Hope Retreat St., 28 Ward. ~~Not Known~~

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Not Known mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs Kowolski

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	35	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (?)
(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country) Poland

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown.

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Retreat.

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 12- 1922, to Feb 9th 1923,
that I last saw him alive on Feb 9th 1923
and that death occurred, on the date stated above, at 1.15 P. m.
The CAUSE OF DEATH* was as follows:

Paresis (Specify -)

abt (duration) 1 yrs. 3 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia Paretic -
abt (duration) 1 yrs. 3 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? W. Test.

(Signed) Frank J Flannery, M. D.

Feb 9th 1923 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Feb 13 1923
20 UNDERTAKER	**ADDRESS**
John F. Weber	803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72330

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

D72330

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 101 S Garrison Ave St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen R. Hagan

(Residence in Baltimore: No. 101 S Garrison Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Nov (Month) 1 (Day) 1922 (Year)

7-AGE. ..... yrs. 3 mos. 10 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER, Ralph R Hagan

11-BIRTHPLACE OF FATHER, (State or Country), Frederick Co

12-MAIDEN NAME OF MOTHER, Sophie Bernat

13-BIRTHPLACE OF MOTHER, (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph R Hagan

(Address) 101 S Garrison Ave

15- FEB 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 10 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute congestion of lungs following Influenza

(Duration) ..... yrs. ..... mos. Indefinite ds.

CONTRIBUTORY (Secondary) Acute bronchitis

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) James W Pendleton M. D.

(Coroner.)

Feb 10 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Feb. 12, 1923

20-UNDERTAKER, George L. Schwab — ADDRESS 2101 Fredk. Ave.

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72331

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D72331

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. 95 WARD)

2-FULL NAME Patrick McMahon

(a) RESIDENCE NO. St Marys Industrial ST., 15 WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or Divorced, ~~(write the word)~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): April 18th 1907

7 AGE: Years 15 yrs; Months 10; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Do not Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know

14 Informant: Mrs Ida McMahon (Address) 1008 W Lexington St

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb - 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1922, to Feb 10, 1923, that I last saw him alive on Feb. 10, 1923, and that death occurred, on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis with Decompensation - arteriosclerosis - Chronic Nephritis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) H V Harper M. D.

, 19 (Address) St Agnes Hospo.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery

DATE OF BURIAL: Febry 13th 1923

20 UNDERTAKER: John J Keenan & Son H E[illegible] J Keenan

ADDRESS: 901 Hollins St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72332

CERTIFICATE OF DEATH.

14-001

D72332

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6208 Oak Lane ST. 27 WARD)

2-FULL NAME ERNEST ADAMS GILL

(a) RESIDENCE. No. 6208 Oak Lane ST. 27 WARD. (Resident)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. IO mos. I7 ds. How long in U. S., if of foreign birth? 44 yrs. IO mos. I7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rosalie Price Gill

6 DATE OF BIRTH (month, day, and year) March-24-I878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	IO	I7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary to the Tea

(b) General nature of industry, business, or establishment in which employed (or employer) importing firm of

(c) Name of employer Martin Gillet & Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Ernest Gill

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Blache Dominick

13 BIRTHPLACE OF MOTHER (city or town) Cincinatti
(State or country) Ohio

14 Informant Mr. A.W. Jacobsen (Uncle)
(Address) 309-Oakdale Road Roland Park

15 FEB 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1922, to Feb. 10, 1923, that I last saw h m alive on Feb. 7, 1923 and that death occurred, on the date stated above, at 4¹⁵ P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 15 minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. D. Steenken, M. D.

, 19 (Address) 3949 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: GREEN MOUNT CEMETERY

DATE OF BURIAL: Feb-I2-'23

20 UNDERTAKER: STEWART & MOWEN COMPANY
(WILLIAM F. MOWEN, Successor)

ADDRESS: 108 W. NORTH AVE.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72333
1-PLACE OF DEATH

CERTIFICATE OF DEATH. 100-001 Acad 3169

D72333
REGISTERED NO.

CITY OF BALTIMORE: (No. 1703 Caino ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt. Mitchell

(a) RESIDENCE. No. 1703 Caino ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. - mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Jan 23 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	-	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER Robt Mitchell
11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D. C.
12 MAIDEN NAME OF MOTHER Ruth Burke
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Wm Jackson 1703 Baker

15 FEB 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 8 1923 to Feb 11 1923
that I last saw him alive on Feb 10 1923.
and that death occurred, on the date stated above, at 11.30 P.M.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) over
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) F. C. Link M. D.
Feb 19 (Address) 2108 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Feb. 12 1923
20 UNDERTAKER James N. Dennis	ADDRESS 1303 Freeman

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72334

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D72334

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 Druid Hill St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Soloman Johnson

(a) RESIDENCE. No. 1526 Druid Hill St., 14 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 6 mos. 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 11, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter — 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry Eating Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Pinkie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

11 Informant Pinkie Johnson

(Address) 1526 Druid Hill Ave

15 Filed FEB 12 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 10 19 23

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1922 to Feb 10, 1923, that I last saw h— alive on Feb 7, 1923, and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Hallam B Wright, M. D.

(Address) 1709 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Feb 14 1923
20 UNDERTAKER James F. Dennis	ADDRESS 1,303 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72335

CERTIFICATE OF DEATH.

11-001

D72335

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 528 Lambert St. (Ward) 14

2-FULL NAME Frank Talbott

(a) RESIDENCE. No. 528 Lambert St., Ward. 14

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Emma Talbott

6 DATE OF BIRTH (month, day, and year) Oct 1st 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hackdriver

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer Samuel T Hensley

9 BIRTHPLACE (city or town) (State or country) Tutty Tree Md

PARENTS

10 NAME OF FATHER Wesley Talbott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Trusco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Talbott

(Address) 528 Lambert St

15 Filed FEB 12 1923 . 19

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1923, to July 9, 1923, that I last saw h[illegible] alive on July 9, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

Bronchial Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilat

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Chas P Clark M. D.

July 9, 1923 (Address) 1504 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tutty Tree Cem.

DATE OF BURIAL Feb 11 1923

20 UNDERTAKER Samuel T Hensley

ADDRESS 528 Mcdd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72336

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72336

CERTIFICATE OF DEATH.

3/1

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 236 S Spring St. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Ransom

(a) RESIDENCE NO. 236 S. Spring ST. 3 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Ransom

6 DATE OF BIRTH (month, day, and year) Sept 27, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37 yrs	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer building 040

(b) General nature of industry, business, or establishment in which employed (or employer) Labor on erection of building

(c) Name of employer Hechinger Yard Co.

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER John Ransom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maria Walton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary Ransom (Address) 236 S Spring St

15 FEB 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7 1923 to Feb 9, 1923, that I last saw him alive on Feb. 8, 1923 and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Richard Eustice M. D.

(Address) 1514 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel

DATE OF BURIAL Feb 12 1923

20 UNDERTAKER John A Henderson

ADDRESS 1502 Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72337.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72337

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — PARSONS — REGISTERED NO.

CITY OF BALTIMORE: (No. 1007 E. Hoffman ST.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Parsons

(a) RESIDENCE. No. 1007 E. Hoffman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6yrs yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): Dec 23. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: No

(b) General nature of industry, business, or establishment in which employed (or employer): No

(c) Name of employer: No

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Francis E. Parsons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Margaret Knoop

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Mrs Margaret Parsons Mother 1007 E. Hoffman St

Filed FEB 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 11. 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27. 1923. to Feb. 11. 1923.

that I last saw h[illegible] alive on Feb. 11. 1923.

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None.

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. W. Magness, M. D.

Feb. 11. 1923 (Address) 1806 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: Feb. 12. 1923

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 814 E. Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72338

CERTIFICATE OF DEATH.

90 D72338

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Home for Aged & Infirm St., 6 WARD)

2-FULL NAME Chaya Rose Whiteman

(a) RESIDENCE NO. 2500 E Balto Street ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barel Whiteman

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Baruch Moessings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Moessings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) D Lewis 1439 E Balto St

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-11 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1923, to Feb 11, 1923, that I last saw h alive on Feb 11, 1923, and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo Baruch, M. D.

2/12, 1923 (Address) 24 hours

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int Carmel — DATE OF BURIAL 2/12 1923

20 UNDERTAKER Jack Lewis 1439 E Balto St — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72339 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 101-001 D72339

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE? (No.) 1706 N Monroe St., 15 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer Sharoff

(a) RESIDENCE NO. 1706 N Monroe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Schoroff

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old age

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Schoroff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Ki Cohen 1431 E Fayette St Kolker Bros

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-12 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 6, 1923, to Feb 11th, 1923, that I last saw him alive on 2/10, 1923, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Schonfeld, M. D.

, 19 (Address) 2328 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL 2/12 1923

20 UNDERTAKER Jack Levy — ADDRESS 1439 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D72340

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72340

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 208 Grindall St. St. 24 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Stratton. 45 ----------.

(Residence in Baltimore: No. 208 Grindall Street. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female.	White.	Widow.

6-DATE OF BIRTH, Do not know. 1.....
(Month) (Day) (Year)

7-AGE. 68 yrs. -- mos. --- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Ireland.

PARENTS

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER, (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Robert Lockhead. (daughter)

(Address) Fayettsville, N.C.

15- FEB 12 1923 ROBERT R. KRAUTER
Filed 192 Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 9th, 1923. 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

Feb. 12, 1923. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Holy Cross A A Co	Feb 13 1923
20-UNDERTAKER. John F Denny	ADDRESS 715 Light St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001

D72341

D72341

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Lancaster ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Collinson

(a) RESIDENCE NO. 1513 Lancaster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., If of foreign birth? yrs. 10 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr. 25- 1922

7 AGE — Years: — Months: 10 — Days: 15 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Edward Collinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Mary Ruckli

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baeto

14 Informant: Ed. Collinson (Address): 1513 Lancaster St

15 FEB 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 10 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1923, to Feb 10, 1923,

that I last saw him alive on Feb. 10, 1923,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Ratzenger, M. D.

, 19 (Address) 1709 Eden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary.

DATE OF BURIAL: 2/12 1923

20 UNDERTAKER: William Fiaschetti

ADDRESS: 168 East

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

STAHL

HEALTH DEPARTMENT--CITY OF BALTIMORE

D72342

D72342

CERTIFICATE OF DEATH

100-001

Registered No. C

1-PLACE OF DEATH

City of Baltimore (No. 3320 Foster Ave St. No Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Elsie Stahl

(Residence in Baltimore: No. 3320 Foster Ave. St.: 3 yrs. 7 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: F

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: May (Month) 13 (Day), 1923 (Year)

7-AGE: 2 yrs. 8 mos. 27 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Joseph Hollerman

11-BIRTHPLACE OF FATHER (State or country): Md.

12-MAIDEN NAME OF MOTHER: Helen Stahl

13-BIRTHPLACE OF MOTHER (State or country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Catherine Foster

(Address) 3320 Foster Ave.

15- FEB 12 1923 Filed ....., 191.... ROBERT R. KRAUTER, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Feb. (Month) 10 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1923, to Feb 10 1923, that I saw her alive on Feb 10, 1923, and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia post Measles

(Duration) ..... yrs. ..... mos. 12 ds

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank A. Geanty M. D.

Feb. 13, 1923 (Address) 3244 Eastern ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Secrest Mem'l Cem.

DATE OF BURIAL: Feb 12th, 1923

20-UNDERTAKER: Lilly Feiler

ADDRESS: 438 Park Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72343

CERTIFICATE OF DEATH.

74-001

D72343

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Hollins ST.; 14th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Corilla Holland

(Residence in Baltimore: No. 1604 Hollins St.; .....yrs., ...mos. .....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, March 10, 1842 (Month) (Day) (Year)

7-AGE, 81 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Hamm[illegible] Shipley

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Susan Fox

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs W C Sellers

(Address) 1428 Hollins Ave

15- FEB 12 1923 ROBERT R. KRAUTER,
Filed....., 191.....
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 11, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 9 1923, to Feb 11 1923, that I saw her alive on Feb 11 1923, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) .....yrs. .....mos. 2 ds.

(Signed) Jesse E. Sellers M. D.

Feb 11 1923 (Address) 1520 Hollins Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lounden Park — DATE OF BURIAL, Feb 14, 1923

20-UNDERTAKER George J Smith — ADDRESS 15[illegible] Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72344

D72344

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 519 N Bruce (St.) 20 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. May E Flaherty

(a) RESIDENCE. No. 519 N Bruce St. WARD. 20

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jno. P Flaherty

6 DATE OF BIRTH (month, day, and year): Dec 29-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Fred A Sawtelle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Virginia Whitney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Jno B Flaherty 519 N Bruce St

15 FEB 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 8th 1923 to Feb 11 1923, that I last saw h[illegible] alive on Feb 8th 1923, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary): Toxemia of Pregnancy

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy Dwelly M. D.

(Address) 400 W Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Feb 13 1923

20 UNDERTAKER: George J Smith — ADDRESS: 1532 Baltimore

Mason should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14-001

D72345

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Women Home ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E B Platt

(a) RESIDENCE. NO. 1400 W Lexington ST., 19 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Platt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Wilson

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Ella Jones
(Address) 1400 W Lexington St

15 Filed , 19 ROBERT R. KRAUTER, Registrar
FEB 12 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923, to Feb 11, 1923, that I last saw h alive on Feb 10, 1923, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Hoozwood M. D.

Feb 12, 1923 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 7 Feb 13 1923

20 UNDERTAKER George J Smith — ADDRESS 1533 Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72346

CERTIFICATE OF DEATH.

90 D72346

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 236 S.Ann ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E.McWilliams

(a) RESIDENCE. NO. 236 S.Ann ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced, HUSBAND of Martha Jane McWilliams

6 DATE OF BIRTH (month, day, and year) Sept.12.1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	4	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) watchman

(c) Name of employer Masonic Temple

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Edward McWilliams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Sterling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Martha Jane McWilliams(wife)
(Address) 236 S.Ann.St.

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb.11.1923 19

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1922, to July 11, 1923, that I last saw her alive on July 10, 1923, and that death occurred, on the date stated above, at 6.15 A m.

The CAUSE OF DEATH* was as follows:

Pleurisy

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R.T.Davis M. D.

, 19 (Address) 1509 N.Carolina Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	2-14-23 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72346 Cl 347

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D72347

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., WARD 8

2-FULL NAME James Eugene Welch

(a) RESIDENCE NO. 240 E. Eliza St ST., WARD 8

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 7-1922

7 AGE: Years — Months 3 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry Welch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elsie Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11- 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7- 1923, to Feb 11- 1923.

that I last saw him alive on Feb 11- 1923,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Multiple Thrombosis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Norton Caspari M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Feb. 12th 1923

20 UNDERTAKER E. J. Fanning & Son - 1938 Lafayette Ave. — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72348

D72348

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1505 W. Saratoga ST.: 19 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Douglas A. Fields

(a) RESIDENCE. NO. 1505 W. Saratoga St. ST., WARD. 19

(Usual place of abode) dont (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Sarah Fields

6 DATE OF BIRTH (month, day, and year) July 4 - 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Day labor

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Rochester N. Y.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Margaret Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Sarah Fields (Address) 1505 W. Saratoga

15 FILED FEB 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10- 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7- , 1923 , to Feb. 9- , 1923 , that I last saw ~~him~~ alive on Feb. 9- , 1923 , and that death occurred, on the date stated above, at 4-45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

dont (duration) — yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Exam. of urine

(Signed) Thos. McCarthy , M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cem. DATE OF BURIAL: Feb 13 1923

20 UNDERTAKER: A. Jones ADDRESS: 111 S. Gilmor St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D72349

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 518 Hanover St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... James Gorman

(Residence in Baltimore: No. 518 Hanover St.; yrs. 10 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	colored	Married

6-DATE OF BIRTH. Oct. 20, 1857
(Month) (Day) (Year)

7-AGE. 51 yrs. 3 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

9-BIRTHPLACE, (State or Country) Calvert Co, Md.

PARENTS.

10-NAME OF FATHER, [redacted] Smith

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Eliza Smith

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lula Brown

(Address) 544 S. Eutaw St.

15- FEB 12 1923

Filed ..... 192.....

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 9, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.c.q. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Ac. Gastro-enteritis

(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) J. T. Steuart M. D.
(Coroner)

Feb. 12 192 3 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Auburn	Feb. 12 1923

20-UNDERTAKER,	ADDRESS
Mrs. J. J. Locke	1302 Hoffman

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72350

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72350

CERTIFICATE OF DEATH

1-PLACE OF DEATH Pronounced Dead at 90

City of BALTIMORE: (No. St Agnes Hospital Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Miller

(Residence in Baltimore: No. 2002 Mc Henry St.; yrs. 41 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Oct (Month) 4 (Day) 1881 (Year)

7-AGE. 41 yrs. 4 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Circus

9-BIRTHPLACE, (State or Country). Gold City

PARENTS.

10-NAME OF FATHER, August Miller

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Margaret Hiller

13-BIRTHPLACE OF MOTHER, (State or Country). Gold City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Miller

(Address) 1611 Mc Henry St

15- Filed FEB 12 1923 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 8 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis, cause unknown Duration to determine.

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) acute dilatation of heart, while bowling Duration yrs. mos. ds.

(Signed) James M Benton M. D.

(Coroner.)

Feb 9 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Woodlawn Cemetery DATE OF BURIAL. Feb 12 1923

20-UNDERTAKER. Harry Weitzel ADDRESS 1514 W Lombard

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state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72351

D72351

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 948 (St.) Aisquith (Ward) 10

2-FULL NAME. Blanche A. Christopher

(a) RESIDENCE NO. 948 (St.) Aisquith (Ward) 10

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 5 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard G. Christopher

6 DATE OF BIRTH (month, day, and year): Aug. 20 1893

7 AGE — Years: 29 — Months: 5 — Days: 20 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Patrick Fratis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Sonia Sottes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mrs Estelle E. Fratis

(Address) 948 Aisquith St

15 Filed FEB 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 10 1923

17 I HEREBY CERTIFY, that I attended deceased from January 23 1923 to Febry 10 1923

that I last saw her alive on Febry 10 1923,

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Louis H. A. Meyer, M. D.

Feb 10. 1923 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Feb. 15 1923

20 UNDERTAKER: Henry Hoeck & Son — ADDRESS: 1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72352

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72352

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John J. Hopkins

(Residence in Baltimore: No. 814 Ewsor St., 10 yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Single

6-DATE OF BIRTH. February 21 (Month) (Day) 1901 (Year)

7-AGE. 21 yrs. 11 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Slate
(b) General nature of industry, business, or establishment in which employed (or employer). Roofer

9-BIRTHPLACE. (State or Country) Balto. Md

PARENTS.

10-NAME OF FATHER. Michael J. Hopkins

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary A. Moloney

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Michael J. Hopkins

(Address) 814 Ewsor St

15-

Filed FEB 12 1923 ROBERT R. KRAUER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb. 10 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

*1. Alcoholism

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis

(Duration) yrs. mos. ds.

(Signed) Geo. Edward Hobbs M. D. (Coroner)

Feb 11 1923 (Address) 1431 Eden Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St. Peters Cemetery	February 14 1923
20-UNDERTAKER,	ADDRESS
Henry Hoeck & Son	1301 E Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72353 Guilford

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-002 D72353

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
S.E. Cor.
CITY OF BALTIMORE: (No. Wendover & Juniper Rd ST., 12 WARD)

2-FULL NAME Delia Allen Evans.

(a) RESIDENCE No. Wendover & Juniper Rd ST., Guilford WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married,~~ Widowed, or Divorced, (write the word): Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Thomas R. Evans

6 DATE OF BIRTH (month, day, and year): 1848-7-24

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Morgantown W. Va

PARENTS

10 NAME OF FATHER: Guy R.C. Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Parkersburg Virginia

12 MAIDEN NAME OF MOTHER: Delia Lowry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Morgantown W. Va

14 Informant: E. C. Miller
(Address): Juniper & Wendover Rd

15 Filed 12 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb., 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb., 10, 1923, to Feb., 12, 1923, that I last saw h[illegible] alive on Feb., 11, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Cerebral Embolism

(duration) ..... yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Wendover & Juniper Rd

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) Jack H. Mayo M. D.

2-12, 1923 (Address) 6 E. Fayette St. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Morgantown W. Va

DATE OF BURIAL: 2-12 1923

20 UNDERTAKER: H.W. Fuscins Sons Co.

ADDRESS: McCulloh & Orchard.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72354

D72354

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Registered No. C.....

City of BALTIMORE: (No. 654 W. Lombard St. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matthew Scott

(Residence in Baltimore: No. 654 W Lombard St. St.; 5 yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Feb (Month) 4 (Day) 1861 (Year)

7-AGE: 62 yrs. ... mos. 8 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Veterinary Surgeon
(b) General nature of industry, business, or establishment in which employed (or employer): 186

9-BIRTHPLACE, (State or Country): Pa.

PARENTS.

10-NAME OF FATHER: Matthew H Scott

11-BIRTHPLACE OF FATHER, (State or Country): England

12-MAIDEN NAME OF MOTHER: Ann Bettle

13-BIRTHPLACE OF MOTHER, (State or Country): England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Scott

(Address) Sykesville Md

15-

FEB 12 1923 192...

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 12 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) ... yrs. Don't Know mos. ... ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. K. Zouck M. D.
(Coroner.)

2-12 1923 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State 5 yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: Mount's Cemetery — DATE OF BURIAL: Feb 14 1923

20-UNDERTAKER: Jas. R. Shaw — ADDRESS: Sykesville

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72355

CERTIFICATE OF DEATH.

129

D72355

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 E. Cross St. ST.: ~~24th~~ 24 WARD)

2-FULL NAME Richard Alexander Hodges Jr

(a) RESIDENCE. NO. 130 E. Cross St. ST., 24th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Minnie Hodges.

6 DATE OF BIRTH (month, day, and year) ~~March 5~~ March 5, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

086

9 BIRTHPLACE (city or town) (State or country): Rock Hall, Kent Co., Maryland.

PARENTS

10 NAME OF FATHER: Richard Alexander Hodges Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rock Hall, Kent Co, Maryland.

12 MAIDEN NAME OF MOTHER: Mary Matilda Harper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Still Pond, Kent Co, Maryland.

14 Informant (Wife) Minnie Hodges

(Address) 130 E. Cross St.

Filed FEB 12 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923 to Feb 12, 1923.

that I last saw him alive on Feb 11, 1923

and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? ~~Henry F. Buettner~~

(Signed) Henry F. Buettner M. D.

. 19 (Address) 1273 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hall Md.	2-15-1923
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E. North Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D. 72356 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 72356

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2628 Edmondson Ave ST. 16 WARD)

2-FULL NAME Mary F Walters

(a) RESIDENCE NO. 2628 Edmondson Ave ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert F Walters

6 DATE OF BIRTH (month, day, and year): 5/3/70

7 AGE — Years: 53 Months: 9 Days: 11 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 87

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Owen Morton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Virginia Wade

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mr Walter Walters
(Address): 2628 Edmondson Ave

15 ROBERT P. MATTHEWS, ... 19 .....
Registrar
Burial Permit Clerk.

2 12 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 10 1923

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1923, to Feb 10, 1923,
that I last saw h[illegible] alive on Feb 10, 1923,
and that death occurred, on the date stated above, at 11.05 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

Chronic Interstitial Nephritis

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) [signature] M. D.

2/11, 1923 (Address) Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bonnie Brae — DATE OF BURIAL: 2/13/1923

20 UNDERTAKER: J. F. Fahey & Sons. — ADDRESS: 1318 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72357

CERTIFICATE OF DEATH.

74-001

D72357

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 525 North Charles ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard J. Connolly

(Residence in Baltimore: No. 525 North Charles St.; 56 yrs., ... mos. ..... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) 1867 (Year)

7-AGE, 56 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Letter carrier
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Hugh Connolly

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Kate Lisby

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. A. Connolly

(Address) 525 N. Charles St.

15- Robert P. Harrison,

Filed ....., 191.....

2 12 1923 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 10th, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 10th, 1923, to February 10th, 1923, that I saw h.im alive on February 10th, 1923, and that death occurred, on the date stated above, at 1230 p. m.

The CAUSE OF DEATH* was as follows:

Uremia. Sclerosis.
Cerebral Hemorrhage
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(Duration) ....yrs. ....mos. ....ds.

(Signed) Edgar Stanley Perkins M. D.

Feby 10th, 1923. (Address) 1 W. Franklin St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Cathedral

DATE OF BURIAL, 2/13, 1923

20-UNDERTAKER J. F. Talbert & Sons

ADDRESS 338 Light St.

Spec.—1-10-21—M&T—1500 Bks.

D72358

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72358

CERTIFICATE OF DEATH.

160

1-PLACE OF DEATH St Vincents Infr Asy.

REGISTERED NO.

CITY OF BALTIMORE: (No. 1401 Division ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Smith

(a) RESIDENCE NO. 1401 Division ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 9 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Isabel Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant St Vincents Infr Asylum

(Address) 1401 Division St

15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb'y 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1922, to Feb'y 10, 1923

that I last saw him alive on Feb'y 9, 1923,

and that death occurred, on the date stated above, at — 3 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(duration) yrs. 3 mos ds.

CONTRIBUTORY - (Secondary) Insanity —

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. R. Gold Coroner's M. D.

, 19 (Address) 4735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL Feb 13 1923

20 UNDERTAKER Mathias Frahm Son

ADDRESS 427 N North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3 12 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72359

CERTIFICATE OF DEATH.

35 D72359

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hosp. (St.:) 8 (Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Lucking

(a) RESIDENCE. No. 2102 E. Preston St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Lucking

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE: Years 63; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

013

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Herman Lucking

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Eichmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Bernard J. Lucking 2826 Raspe Ave

15 [illegible] Registrar

B 1 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1923 to Feb. 11, 1923, that I last saw him alive on Feb. 11, 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic infection

St. Luce (duration) yrs. (one) mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Conrad Konstowski, M. D.

, 19 (Address) St. Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: Feb 13 1923

20 UNDERTAKER: Martin Fahey Son

ADDRESS: 2780 North

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should FILL CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72360 D72360

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt. Washington 6 Roxbury Place ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. O'Brien

(a) RESIDENCE No. 6 Roxbury Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred about 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	78	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D. C.

PARENTS

10 NAME OF FATHER Do not Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not Know

12 MAIDEN NAME OF MOTHER Do not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not Know

14 Informant N. Irvin Gressitt

(Address) 1101 Fidelity Building

15 Filed 2 12 1923, 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-11 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1922, to Feb 11, 1923.

that I last saw her alive on Feb 11, 1923,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 4 mos 11 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) E Gill Hall M. D.

Feb 12 1923 (Address) 1617 E North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Glenwood Cemetery, Wash. D. C. DATE OF BURIAL: 2/12/1923

20 UNDERTAKER: Henry W. Mears & Son ADDRESS: 805 Calvert

Via Automobile. N. Irvin Gressitt, Escort.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

12 1923

D72361

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72361

CERTIFICATE OF DEATH.

118-002

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Womans Hospital ST. 14th WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida H. Beck

(Residence in Baltimore: No. 218 Laurens St. St.; yrs. 26 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Dec. 5, 1886
(Month) (Day) (Year)

7-AGE, 16 yrs. 2 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, C. H. Bollman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Eliza Fleter

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Julia H. Beck

(Address) 218 Laurens St.

15- Robert P. Harrison,
....., 191.....
Burial Permit Clerk. Registrar.

FEB 7 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 11, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer
Probably due to adhesions
(Duration) ....yrs. ....mos. 1 ....ds.

CONTRIBUTORY (Secondary) Operation (3 hrs)
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Hennessy M. D.
(Coroner.)

Feb 12, 1923 (Address) 711 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death Womans Hosp. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 218 Laurens St.

Former or usual residence same

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Feb. 13, 1923

20-UNDERTAKER Robert J. Little ADDRESS 2405 Greenmount Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should take CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72362

CERTIFICATE OF DEATH.

49

D72362

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3840 Falls Road ST.: 13 WARD)

2-FULL NAME Joseph M. McCann

(a) RESIDENCE. NO. 3840 Falls Road. ST., 13 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 25-1849

7 AGE — Years: 73 Months: 4 Days: 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 20 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Michael McCann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Rosanna C. Friel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Charles Connor (Address): Cathedral St.

15 2 12 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from April, 1922, to Feb 11, 1923, that I last saw him alive on Feb 11, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo W Wermuth, M. D.

2/11, 1923 (Address) 2020 N. Haven

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's (Govans) — DATE OF BURIAL: Feb. 14 1923

20 UNDERTAKER: Norad F. Burgee — ADDRESS: 363 Fallsway

Notice should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72363

D72363

CERTIFICATE OF DEATH.

11-002

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 421 S. Bentalou (St.) 70 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Kahn

(a) RESIDENCE. No. 421 S. Bentalou St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? 38 yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Kahn

6 DATE OF BIRTH (month, day, and year): Jan 14 - 1850

7 AGE — Years: 73 — Months: ✓ — Days: 27 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Farming

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Jacob Kahn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katharina Erichman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): John Kahn, 134 N. Clymont

Feb 16 1923

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923, to Feb 10, 1923, that I last saw him alive on Feb 10, 1923, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Influenza (duration) about 1 week ds.

CONTRIBUTORY (Secondary) Left Bronchopneumonia, complicating Senile Arteriosclerosis (duration) about 5 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Henry G. Lake M. D.

Feb 16 1923 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel

DATE OF BURIAL: 2/14 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 Valley

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

12 1923

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72364 D72364

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph Hospital — 90 REGISTERED NO.....

CITY OF BALTIMORE: (No. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Wrightson

(a) RESIDENCE No. 1804 Dukeland Ave. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marion H. Wrightson

6 DATE OF BIRTH (month, day, and year): Nov 9 1879

7 AGE — Years: 43 — Months: 3 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer): Vacuum Sales Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Marys Co Md

PARENTS

10 NAME OF FATHER: Vaughn Wrightson

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Marys Co Md

12 MAIDEN NAME OF MOTHER: Ida Tennison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys Co Md

14 Informant: Marion H. Wrightson
(Address): 1807 Dukeland Ave

15 Filed 12 1923 19 Robert F. Hartless, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1923, to Dec. 12, 1923, that I last saw h alive on Dec. 12, 1923, and that death occurred, on the date stated above, at 2 45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) — Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P S & S.

(Signed) Harold C. Gillespy, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 12/15 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 512 E North

Marion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72365

CERTIFICATE OF DEATH.

D72365

131

8

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital. ST., WARD)

2-FULL NAME Henry Arndt

(a) RESIDENCE NO. 1606 Port St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
56	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed ..., 19 ... Robert P. Harrison, Registrar

8 12 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 1923

17

I HEREBY CERTIFY, That I attended deceased from February 9, 1923. to February 11 1923.

that I last saw him alive on February 10, 1923.

and that death occurred, on the date stated above, at 5:10 A.M.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. U. McKay, M. D.

2-12-49 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 2/13 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D72366

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72366

CERTIFICATE OF DEATH.

129

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 Edmonson ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mary A. McCann

(Residence in Baltimore: No. 114 Edmondson St.; yrs. 26 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. May 12, 1852 (Month) (Day) (Year)

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Antrim Ireland

PARENTS.

10-NAME OF FATHER. John McCann

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Eliz Wiley

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachel Jones

(Address) 114 Edmondson ave

15-

Filed 1923 Robert F. Carrison, Registrar.

12 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 11, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(Duration) 2 yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

Feb 12 1923 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral — DATE OF BURIAL. 2-15 1923

20-UNDERTAKER. J. C. Young Sons — ADDRESS 517 N. Howard St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72367

CERTIFICATE OF DEATH.

11-002

D72367

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Parish ST., 16 WARD)

2-FULL NAME Robt. J. Thomas

(a) RESIDENCE NO. 1121 Parish ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE: Years 33; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: Grace Queen (Address) 1121 Parrish St

15 FEB 13 1923 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/9 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/2, 1923, to 2/9, 1923.

that I last saw him alive on 2/9, 1923

and that death occurred, on the date stated above, at 7 35 P m.

The CAUSE OF DEATH* was as follows:

Ac. Gastro-enteritis

Exhaustion

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno. L. Getty, M. D.

2/11, 1923 (Address) 2139 Dth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cem

DATE OF BURIAL: 2-13-1923

20 UNDERTAKER: Daniel Easton

ADDRESS: Balto

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72368

CERTIFICATE OF DEATH.

11-001

D72368

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 720 W. Bradley ST., 11 WARD)

2-FULL NAME Viola Bailey

(a) RESIDENCE NO. 720 W Bradley ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Blk	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	17	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Belle Haven Va

PARENTS

10 NAME OF FATHER Herbert Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Belle Haven Va

12 MAIDEN NAME OF MOTHER Lulia Sample

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Va

14 Informant Jas Harrmanson
(Address) 720 Bradley

15 FEB 13 1923 ROBERT A. HABLIL, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/9 , 1923 , to 2/11 , 1923 ,
that I last saw her alive on 2/11 , 1923 ,
and that death occurred, on the date stated above, at 12:15P m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Gustav Goldman , M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 2-13-1923

20 UNDERTAKER Daniel Carbo

ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Beale

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72369

D72369

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 1720 Division ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Burrel B. Beale

(Residence in Baltimore: No. 1720 Division St.; 63 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov. 1, 1859 (Month) (Day) (Year)

7-AGE, 63 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Packing Co.

9-BIRTHPLACE, (State or Country), Balt. Md.

PARENTS.

10-NAME OF FATHER. James Beale

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER. Rebecca Beale

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Bryan

(Address) 1720 Division St.

15-

Filed FEB 13 1923, 191 ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 10th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 7th 1923, to Feb. 10th 1923, that I saw h[illegible] alive on Feb 9th 1923, and that death occurred, on the date stated above at 4A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Syphilis Infantile

(Duration) C yrs. mos. 1/4 ds.

(Signed) A. L. Lee Elkins M. D.

Feb 10, 1923. (Address) 5 E. Pleasant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Lt Peters Cem

DATE OF BURIAL, 2-13-23, 191

20-UNDERTAKER David Easton

ADDRESS 916 Ba Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72370 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164

REGISTERED NO. D72370

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Little Sisters of the Poor 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Reed

(a) RESIDENCE. No. Preston & Valley Sts. ST., WARD.

(Usual place of abode) (If nonres ident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert A. Reed

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Thorpe

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant & Sister Florence, (Address) Preston & Valley

15 Filed FEB 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-11 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-10, 1923, to 2-11, 1923, that I last saw h Sr alive on 2-10, 1923, and that death occurred, on the date stated above, at 8. a. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) Unknown ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Sachs, M. D.

2/14, 1923 (Address) 914 E Broadway

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Balto DATE OF BURIAL 2-13 1923

20 UNDERTAKER David Barton ADDRESS 916 Pa ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72371

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D72371

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 27 N. Spring ST., 5 WARD)

2-FULL NAME Maggie Jacobs

(a) RESIDENCE NO. 27 N. Spring ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Oct 28 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	37	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER John Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Annie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant (Address) Mary Jones 27 N. Spring

15 FEB 13 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923 to Feb 9, 1923, that I last saw him alive on Feb 9, 1923 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Arrhythmia

(duration) yrs. mos. 1 hr.

18 Where was disease contracted if not at place of death? 27 N. Spring St

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Albert L. Levy M. D.

(Address) 1235 E. Monument St Feb 9 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D C

DATE OF BURIAL Feb 13 1923

20 UNDERTAKER R C Groff

ADDRESS 1405 McElderry St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72372 HEALTH DEPARTMENT—CITY OF BALTIMORE D72372

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1207 W. Franklin (St.) 18 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence A. Spencer

(a) RESIDENCE. No. 1207 W. Franklin St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas W. Spencer

6 DATE OF BIRTH (month, day, and year) Sept 6, 1889

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
33	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bath (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Martin.

11 BIRTHPLACE OF FATHER (city or town) Bath (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Charles W. Spencer (Address) 1207 W. Franklin St.

15 FEB 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1922, to Feb. 12, 1923, that I last saw h er alive on Feb 11, 1923, and that death occurred, on the date stated above, at 9:25 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Arteriosclerosis - Hypertension
Uremia
Childhood (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Renal and Blood tests

(Signed) Leslie M. Gay, M. D.

, 19 (Address) 1014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Feb 16 1923

20 UNDERTAKER Voltz and Lee — ADDRESS 1723 N. Eutaw St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72373

CERTIFICATE OF ~~DEATH~~

101-001

D72373

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital via Monument St.

CITY OF BALTIMORE: (No.) ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Herd Kushner

(a) RESIDENCE No. St Mary's Industrial School Baltimore

(Usual place of abode) Inmates Residence ST. WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 19 yrs; Months —; Days —; If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Attending St Mary's Industrial School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Hyman Kushner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Rebecca Kushner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: L. Rosenwein (Address) 111 N Broadway

15 Filed FEB 13 1923 ROBERT R. KNAUER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 12 23

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 19 23, to Feb 12, 19 23, that I last saw him alive on Feb 12, 19 23, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Acute Cardiac Dilatation (duration) 2 hrs

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) 9 days yrs. mos. ds.

18 Where was disease contracted if not at place of death? St Mary's Ind School Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) I. Greenberg M.D.

2/12 19 23 (Address) Hebrew Hospital Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Het Mt Carmel — DATE OF BURIAL 2/14 1923

20 UNDERTAKER: L. Hirsch & Bro — ADDRESS 127 E Balto St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72374

CERTIFICATE OF DEATH.

1179 D72374

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hebrew Hosp. St.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Tabachman

(Residence in Baltimore: No. 1734 E Balto St St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	white	Single

6-DATE OF BIRTH, Unknown (Month) (Day) (Year)

7-AGE, 6 yrs. 6 mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Israel Tabachman

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Leah Tabachman

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H Tabachman

(Address) 12 S Bond St

15- Filed FEB 13 1923 191. ROBERT N. KRAUTER, Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2/12, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental - Fracture of skull, 2nd degree burns of both legs & both arms, left chest (Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (Coroner) (Duration) yrs. mos. ds.

(Signed) J S O'Calla M. D. (Coroner.)

2-12 191.3 (Address) 10 E Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Hill Carroll	2-15-23
20-UNDERTAKER	ADDRESS
Mat Levinson	Balto St E

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72375 D72375

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2951 Cedar ave. (ST.) (13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eldrad Gorman Webb.

(a) RESIDENCE NO. 2951 Cedar ave ST., WARD Toddville Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 9 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. 4 COLOR OR RACE: White 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none.

6 DATE OF BIRTH (month, day, and year): April 24/1902.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	9.	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Toddville Md.

PARENTS

10 NAME OF FATHER: John H. Webb.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co. Md.

12 MAIDEN NAME OF MOTHER: Victoria J. Todd.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Toddville Md.

14 Informant (Address): John H. Webb. 2951 Cedar ave.

15 Filed FEB 13 1923 ROBERT N. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1923, to Feb. 11, 1923.

that I last saw him alive on Feb. 11, 1923.

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Frank H. Machin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery Baltimore, Md.

DATE OF BURIAL: 2/13. 1923.

20 UNDERTAKER: Walter Davis

ADDRESS: 3307 Maine St

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72376
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 D72376
REGISTERED NO.

CITY OF BALTIMORE: (No. Bay View Hospital ST., 12 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edward Brown

(a) RESIDENCE NO. 2604 Benson ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Brown

6 DATE OF BIRTH (month, day, and year) Sept. 25-1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
58	4		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laboratory assistant
(b) General nature of Industry, business, or establishment in which employed (or employer) Tuberculosis 186
(c) Name of employer Bay View Hospital

9 BIRTHPLACE (city or town) (State or country) Harrisburg, Pa.

PARENTS
10 NAME OF FATHER C Rankin Brown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Harrisburg, Pa.
12 MAIDEN NAME OF MOTHER Katherine Clark
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harrisburg, Pa.

14 Informant Hospital Record.
(Address) Bay View Hospital.

15 Filed FEB 13 1923 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4 1923, to Feb. 11 1923, that I last saw h alive on Feb. 6 1923, and that death occurred, on the date stated above, at 7:40 P.m.

The CAUSE OF DEATH* was as follows:
General emaciation
(duration) yrs. mos 7 ds.
CONTRIBUTORY (Secondary) Myocardial failure
(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) Hans Randall, M. D.
2/11/1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Dale Cemetery
DATE OF BURIAL 2/13. 1923.

20 UNDERTAKER J. Walter Davis
ADDRESS 3307 Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

D72377 HEALTH DEPARTMENT—CITY OF BALTIMORE D72377

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 645 W Lomberd ST., 4 WARD)

2-FULL NAME Lewanaria Kasinskas

(a) RESIDENCE No. 645 W Lomberd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Nov. 14th 1921

7 AGE 1 Years 2 Months 26 Days | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work - - - -

(b) General nature of industry, business, or establishment in which employed (or employer) - -

(c) Name of employer - -

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Luis Kasinkas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Mary Savkitis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Luis Kasinkas
(Address) 645 W Lomberd Street

15 Filed FEB 13 1923 ROBERT E. LAZZOTTI Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9 1923 to Feb 12 1923 that I last saw h[illegible] alive on Feb 11 1923 and that death occurred, on the date stated above, at 5.30 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings.

(Signed) John A. Buchness M. D.

, 19 (Address) 650 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 13 1923
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72378

D72378

CERTIFICATE OF DEATH.

9

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 Hanford ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Hall

(a) RESIDENCE. NO. 1408 Hanford ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem'l

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Child.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child.

6 DATE OF BIRTH (month, day, and year): Apr 17-1922

7 AGE — Years: — Months: 9 — Days: 26 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Bernard Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va Md

12 MAIDEN NAME OF MOTHER: Annie Gent.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Bernard Hall 1408 Hanford Ave

15 FEB 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1923, to Feb 12, 1923, that I last saw h[er] alive on Feb 12, 1923, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Whooping Cough (duration) ... yrs. ... mos. 14 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No, Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. Edlich M D

Feb 19 (Address) 1313 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Feb 16 1923

20 UNDERTAKER: Chas G. Bailey — ADDRESS: 1426 Jefferson St

Zimmer

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72379 D72379

CERTIFICATE OF DEATH.

91-001

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 1312 Bolton ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Zimmer

(Residence in Baltimore: No. 1312 Bolton St.; 20 yrs., ... mos. ~~..... ds.~~)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	White	Single

6-DATE OF BIRTH, Feb. (Month) 1 (Day), 1857 (Year)

7-AGE. 72 yrs. ..... mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Otto Zimmer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Steinhauer

(Address) 1420 Portland St.

15- Filed FEB 13 1923, 191... ROBERT N. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 12 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2-12 1923, to 2-12 1923, that I saw him alive on 2-12 1923, and that death occurred, on the date stated above, at 2:00 m.

The CAUSE OF DEATH* was as follows:

Rupture of Aneurism of Aorta, Coronary Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. D. Stewart M. D.

2-14-, 1923 (Address) 211 W. Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	2-15-23, 191...
20-UNDERTAKER Patrick O'Connor	ADDRESS 2737 Kenneth Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72380

CERTIFICATE OF DEATH

91-002

D72380

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3806 (ST.) Montgomery (WARD) 28

Forest Park

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Silas H. Metcalfe

(a) RESIDENCE NO. 3806 (ST.) Montgomery Ave (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Metcalfe

6 DATE OF BIRTH (month, day, and year) July 8. 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	79	7	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Optician

(b) General nature of industry, business, or establishment in which employed (or employer) C. H. Metcalfe Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Near Pa Springs Adams Co. Pa.

PARENTS

10 NAME OF FATHER Hiram Metcalfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Barbara Ann Hillman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Mary E. Metcalfe

(Address) 3806 Forest Park Ave

15 FEB 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11. 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 24 - 1921, to Feb 11 - 1923, that I last saw him alive on Feb 10 - 1923, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Senile Arteriosclerosis

(duration) 10 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cox Shelling M. D.

(Address) 4107 Liberty Heights

2-11-1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Feb 13, 1923

20 UNDERTAKER Mrs. John W. Teufel & Son

ADDRESS 801 W Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72381 CERTIFICATE OF DEATH.

161-001

D72381

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 144 East ST., 5 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Young.

(a) RESIDENCE NO. 144 East ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb - 6 - 23

7 AGE	Years	Months	Days	If LESS than 1 day, 15 hrs. or 0 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Boy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Warrenton N.C.

12 MAIDEN NAME OF MOTHER Bessie Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Warrenton N.C.

14 Informant (Address) W.W. Gray Johns Hopkins Hospital.

15 Filed FEB 13 1923 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1923, to Feb 7, 1923, that I last saw h ev alive on Feb 6, 1923, and that death occurred, on the date stated above, at 9 45A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W.W. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner Health, Per. Wm. E. WOODALL

ADDRESS FEB 13 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72382

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72382
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 28 WARD)

2-FULL NAME Mr. Frank Ziere

(a) RESIDENCE NO. 4601 Gall Hall ave ST. Forest Park WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 28 mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Ziere

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gen. house work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER William Ziere

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Etta —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E. Baltimore St

15 Filed FEB 13 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1923, to Feb. 12, 1923, that I last saw him alive on Feb. 12, 1923, and that death occurred, on the date stated above, at 9:00 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach with metastasis to the Lungs

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan. 5, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Louis Marks, M. D.

2-12-1923 (Address) The Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 2-13 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E. Balt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72383

REGISTERED NO.

1-PLACE OF DEATH 2100 E Baltimore

CITY OF BALTIMORE: (No. Uncertain ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Herman

(a) RESIDENCE NO. 2469 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Herman

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Lena Berman

(Address) 2469 Druid Hill Ave

15 FEB 13 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1923, to Feb. 11, 1923,

that I last saw her alive on Feb. 11, 1923,

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J Burden, M. D.

2-13, 1923 (Address) 2010 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Nessing

DATE OF BURIAL 2/13 1923

20 UNDERTAKER Jack Lewis

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72384

D72384

181-001

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Registered No. C.....

City of BALTIMORE: (No. 702 Homestead St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George G. Bond

(Residence in Baltimore: No. 913 Homestead St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Apr (Month) 4 (Day) 1921 (Year)

7-AGE. 1 yrs. 10 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Winfield Bond

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Ella A. Lomax

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John Chaffinch

(Address) 702 Homestead St

15- FEB 13 1923 Filed ..... 192.. ROBERT N. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 14 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas asphyxiation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Peters M. D. (Coroner)

2-13 1923 (Address) 505 E. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Lorraine	Feb 14 1923
20-UNDERTAKER.	ADDRESS
Chenoweth & Son	Chestnut ave

(1-23. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.)

not properly adjusted and caused faulty combustion. (This may be one cause)
Accident.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

Benjamin E Matthews ✓

1353

D72385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72385

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Benj E. Matthews

(a) RESIDENCE NO. Hillsington N.C. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 weeks mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Elizabeth Matthews

6 DATE OF BIRTH (month, day, and year) July 7 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	76	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

186

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Isaac Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Sarah Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1923, to Feb 11, 1923, that I last saw him alive on Feb 11 - 1923, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

? (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility prostatic hypertrophy

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Franklin P Johnson, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dixon North Carolina	Feb 13 1923
20 UNDERTAKER	ADDRESS
Joseph ahrens	221 Bway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D72386

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D72386

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2811 Guilford Ave. ST., 12 WARD)

2-FULL NAME. Elizabeth Jane Jones

(a) RESIDENCE NO. 2811 Guilford Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm.C.Jones Sr.

6 DATE OF BIRTH (month, day, and year) April 25 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	75	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) House-wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Thomas J.Pearson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER Eliza K.Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co. Md.

14 Informant Whitney W.Jones

(Address) 2811 Guilford Ave

15 FEB 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1923, to Feb 10, 1923, that I last saw her alive on Feb 10, 1923, and that death occurred, on the date stated above, at 10.15 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 2½ ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

Dont Know (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of none

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Percy Kemp, M. D.

Feb 11, 1923 (Address) 250 N. Robert St City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Feb 13 1923

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1614239 D72387 — 1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

X 49 D72387 REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Turner

(a) RESIDENCE NO. Bare Hills, Falls Road (Md.) ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Sadie Turner

6 DATE OF BIRTH (month, day, and year) May 10, 1844

7 AGE — Years: 78 | Months: 8 | Days: 1 | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Reason Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Nancy Lgard

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country): Maryland

14 Informant ..... Record. (Address) .....

15 FILED FEB 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from January 26 1923 to February 11 1923, that I last saw him alive on February 11 1923, and that death occurred, on the date stated above, at 12.45 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene C. Shute M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rustton md — DATE OF BURIAL: 2/14, 1923

UNDERTAKER: Geo H Holland — ADDRESS 1631 E Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D72388

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1340 Whitecroft ST.: 15 WARD)

2-FULL NAME Oscar Brown

(a) RESIDENCE. NO. 1340 Whitecroft ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 1888

7 AGE — Years: 34 — Months: 7 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Steel Plant

(c) Name of employer: Not known — Sp. Pa.

9 BIRTHPLACE (city or town) (State or country): Catonsville Md.

PARENTS

10 NAME OF FATHER: Richard Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Catonsville Md

12 MAIDEN NAME OF MOTHER: Sarah Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co. Md.

14 Informant: Chas. Williams

(Address) 1340 Whitecroft St.

15 Filed FEB 13 1923 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2 - 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1923, to Feb 10, 1923, that I last saw h[illegible] alive on Feb 10, 1923, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis - chronic

(duration) yrs. 10 mos. 21 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) William A. Harris, M. D.

, 19 (Address) 1200 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catonsville Western Star Cemetery — DATE OF BURIAL: 2, 14th, 23

20 UNDERTAKER: Fred A. Gibson — ADDRESS: 573 Lanvale St

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Gambrill

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72389

CERTIFICATE OF DEATH.

74-001

D72389

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1033 N. Carey ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mrs. N. Gambrill

(Residence in Baltimore: No. 1033 N. Carey St. St.; 59 yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female

4-COLOR OR RACE, Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day) ....., 1863 (Year)

7-AGE, 59 yrs. — mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Janitor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wm N. Gambrill

(Address) 1033 N Carey St

15-

Filed ..... 191.....

FEB 13 1923

ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 10, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry,) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) Sunday ..... find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) ..... M. D.
(Coroner.)

Feb 12, 1923 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, 2/13/23 19....

20-UNDERTAKER Geo T A Gibson

ADDRESS 573 Lanvale St

Spec. 6-9-19—H. P. Co.—1000 Bks.

D72390

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72390

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1209 Jenkins (St.) 11 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Boldin

(a) RESIDENCE. NO. 1209 Jenkins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced, HUSBAND of (or) WIFE of: Chas. Boldin

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 43 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co. Md.

PARENTS

10 NAME OF FATHER: Joel Bradford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Carling James

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Elsie Hunt 1209 Jenkins St.

15 Filed . 19 — ROBERT A. KRAUTER, Registrar — Burial Permit Clerk

FEB 13 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/10/23

17 I HEREBY CERTIFY, That I attended deceased from Oct 23 1922 to Feb. 10 1923

that I last saw h[er] alive on Feb. 9 1923.

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. B. Hartman, M. D.

2/17 1923 (Address) 1216 O. T. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mountain Hartford Co. — DATE OF BURIAL: Feb 14 1923

20 UNDERTAKER: George T. B. Gibson — ADDRESS: 673 Fairmount

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72391

CERTIFICATE OF DEATH.

31 D72391

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3038 Clifton Park Ter ST., 8 WARD)

2-FULL NAME Margaret J. Proff

(a) RESIDENCE NO. 3038 Clifton Park Ter ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Robt. A. Proff

6 DATE OF BIRTH (month, day, and year): Aug 23-98

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Andrew Smid

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger

12 MAIDEN NAME OF MOTHER: Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Robt A. Proff

(Address) 3038 Clifton Park Ter

15 FEB 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/10 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Feb 10, 1923, that I last saw h-e alive on Feb 9, 1923, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Alan B Lemmon, M. D.

2/12, 1923 (Address) 718 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: 2/13 1923

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72392

CERTIFICATE OF DEATH.

91-002

REGISTERED NO. D72392

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1710½ E Monument ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Poulson

(a) RESIDENCE NO. 1710½ E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ or (or) WIFE of: Oscar J Poulson

6 DATE OF BIRTH (month, day, and year): Nov 29-1850

7 AGE: Years 72 Months 2 Days 13 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Jacob Meyers.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Martha J. Meyers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Mrs Kate Sheats

(Address): 1709 N. Caroline St

15 Filed FEB 13 1923 19 Burial Permit Clerk Registrar

ROBERT N. KNABLEN

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1923, to Feb 11, 1923,

that I last saw her alive on Feb 10, 1923,

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

Arteriosclerosis

(duration) several yrs. mos ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. J. Carman, M. D.

2 11 1923 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bellemont Cemetery — DATE OF BURIAL: Feb 13 1923

20 UNDERTAKER: Chas E. Miller — ADDRESS: 2334 Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72393

CERTIFICATE OF DEATH.

31 D72393

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2226 Jefferson ST., 7 WARD)

2-FULL NAME Charlotte M Lacher

(a) RESIDENCE NO. 2226 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John B Lacher

6 DATE OF BIRTH (month, day, and year): May 2-1896

7 AGE: 26 Years Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Not sure

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not sure

12 MAIDEN NAME OF MOTHER: Not sure

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not sure

14 Informant: Mrs B Lacher

(Address) 2226 Jefferson St

15 Filed FEB 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 5 1922 to Feb 10 1923

that I last saw her alive on Feb 10 1923

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed: Wilbur H Logan M. D.

Feb 11 1923 (Address) 801 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Feb 14 1923

20 UNDERTAKER: Chas C Miller

ADDRESS: 2334 Jefferson St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72394

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 Hand ST., 21 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice M Boone

(a) RESIDENCE NO. 1143 Hand ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm T. Boone

6 DATE OF BIRTH (month, day, and year): March 7, 1886

7 AGE — Years: 36 — Months: 10 — Days: 12 — If LESS than 1 day, hrs. or min.: .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: .....

637

9 BIRTHPLACE (city or town) (State or country): Solomons Md.

PARENTS

10 NAME OF FATHER: J. T. Abbott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Solomons Md.

12 MAIDEN NAME OF MOTHER: Alice Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Solomons Md

14 Informant: Ella Tuft

(Address): 523 Myrtle Ave.

15 Filed FEB 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-12-1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Feb 12, 1923, that I last saw her alive on Feb 12, 1923, and that death occurred, on the date stated above, at 1.30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Maynard Deane, M. D.

, 19 (Address) 1127 Hand Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Solomons Md.

DATE OF BURIAL: 2/13 1923

20 UNDERTAKER: Margaret E Lynn

ADDRESS: 1721 Myrtle Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72395

CERTIFICATE OF DEATH.

100-001 D72395

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1519 Webster St. (ST.) 24 (WARD)

2-FULL NAME Thomas August Allen

(a) RESIDENCE NO. 1519 Webster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen Allen

6 DATE OF BIRTH (month, day, and year): Feb. 6, 1888

7 AGE — Years: 35 — Months: 0 — Days: 5 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): 0/6

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md

PARENTS

10 NAME OF FATHER: Wm. Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md.

12 MAIDEN NAME OF MOTHER: Fannie Murry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): (Mrs. T. A. Allen (wife) 1519 Webster St.

15 Filed FEB 13 1923, 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2 - 11 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/8, 1923, to 2 - 11, 1923, that I last saw him alive on 2 - 11, 1923, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Bronchs-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) acute Bronchitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James G Brown M. D.

, 19 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: 2/14 1923

20 UNDERTAKER: Margaret J. Flynn

ADDRESS: 1422 Light St

D72396

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D72396 REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 812 McDonough ST.) 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Gibson

(Residence in Baltimore: No. 812 McDonough St.; yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, August (Month) 30 (Day), 1878 (Year)

7-AGE, 44 yrs. 5 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... At home

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Gibson

(Address) 812 McDonough St

15-

FILED FEB 13 1923, 191.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 10 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration).....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) J. S. H. Fuller (Coroner) M. D.

2-17, 1923 (Address) 508 6 North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Feb 13, 1923

20-UNDERTAKER Mrs Robert H Elliott ADDRESS 1725 Ashland Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-19-21—M&T—1500 Bks.

D72397 HEALTH DEPARTMENT—CITY OF BALTIMORE D72397

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2537 Mecullh st ST. 13 WARD)

2-FULL NAME Ruben Mas

(a) RESIDENCE NO. 2537 Mecullh st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Mas

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 145

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Louis (Address) 1439 E Baltimore

15 Filed FEB 13 1923 RUBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1920, to Feb. 13, 1923, that I last saw h[illegible] alive on Feb. 12, 1923, and that death occurred, on the date stated above, at 3.50 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

about 5

(duration) yrs. mos. ds.

CONTRIBUTORY. (Secondary) Perforation of Esophagus into trachea & lung

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Theodore N. Ramsay M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrem Mt Carmel — DATE OF BURIAL 2/13 1923

20 UNDERTAKER Jack Louis 1439 E Baltimore — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72398

CERTIFICATE OF DEATH.

89 D72398

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823, Park ave ST., 11 WARD)

2-FULL NAME Bartow Van Ness

(a) RESIDENCE NO. 823, Park ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Jane P. Butler.

6 DATE OF BIRTH (month, day, and year) Nov 1, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Eugene Van Ness

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Helen B. Bargent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md

14 Informant Eb. Van Ness

(Address) 1515 Park ave

Filed FEB 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1923

17

I HEREBY CERTIFY, That I attended deceased from —, 1917, to Feby 12th, 1923,

that I last saw h living alive on Feby 12th, 1923,

and that death occurred, on the date stated above, at 2.15 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus - mural thrombus of endocardium - myocardial infarct. (during anginal attack)

(duration) ✓ yrs. ✓ mos 14 ds.

CONTRIBUTORY (Secondary) Coronary Sclerosis, with previous Pulmonary Embolus (duration) 6 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No.

What test confirmed diagnosis? ✓

(Signed) Eb. Van Ness, M. D.

2.12, 1923 (Address) 1515 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Feby 14 1923

20 UNDERTAKER John B. Spence

ADDRESS 1325, N Caroline, St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72399

CERTIFICATE OF DEATH.

100-001 D72399

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 Jackson Place ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Thomas

(a) RESIDENCE No. 102 Jackson Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. Thomas

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1838

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
85	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Supt. City Engineers Depart.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Edward B. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary F. Thomas

(Address) 102 Jackson Place

15 FEB 13 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/12 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/25, 1923, to 2/12, 1923, that I last saw her alive on 2/11, 1923 and that death occurred, on the date stated above, at 2.20 am m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Breathing Symptoms

(Signed) C J Carroll, M. D.

19 (Address) 1740 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Feb 15 1923

20 UNDERTAKER: Wm. C. Black,

ADDRESS: 927 N. Broadway

A. B. WHITE-LEARNED, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72400

CERTIFICATE OF DEATH.

X 101-001

D72400

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.; 11 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wendel Arndt

(Residence in Baltimore: No. 223 East E Street ST.; Sparrows Point Md. yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH. March (Month) 10 (Day), 1860 (Year)

7-AGE. 62 yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Store Room Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co.

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Dont Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maryland General Hospital

(Address) Linden Ave & Madison

15-FEB 13 1923 ROBERT R. KRAUTER, Filed....., 191..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Feb (Month) 12 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 8 1923, to Feb. 12 1923, that I saw him alive on Feb. 12 1923, and that death occurred, on the date stated above, at 11.30P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Empyema

(Duration) ....yrs. ....mos. 4 ds.

(Signed) Davis H. Weldman M. D.

Dec. 12, 1923 (Address) Md. Gen. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 4 ds. In the State 35 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? At home

Former or usual residence 223 East E Street

19-PLACE OF BURIAL OR REMOVAL, Oak Lawn — DATE OF BURIAL, Feb. 16, 1923

20-UNDERTAKER John F Denny — ADDRESS 715 Ly Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

D72401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D72401

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2745 Preston Place St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Kraft

(Residence in Baltimore: No. 2745 Preston Place St.; 54 yrs., 9 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. Sept 29, 1868 (Month) (Day) (Year)

7-AGE. 77 yrs. 4 mos. 16 ds.

If LESS than 1 day. ....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Butcher
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) Germany.

PARENTS.

10-NAME OF FATHER, Both dead

11-BIRTHPLACE OF FATHER (State or Country), When this man was infant

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Denny

(Address) 2745 Preston Place

15-

Filed FEB 13 1923 ROBERT S. KRAUTER, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby 17, 1923 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from June 1919 to Feby 17 1923, that I saw h im alive on Feby 17 1923, and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH*, was as follows:

Uraemia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 6 yrs. mos. ds.

(Signed) H. L. Kolb M D

....., 191... (Address) 728 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Feb 15, 1923

20-UNDERTAKER, John F Denny — ADDRESS 715 L St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72402

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D72402

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 566 Hanover St. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Geo. W. Smith .....

(Residence in Baltimore: No. 566 Hanover St. St.; yrs. 45 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	single

6-DATE OF BIRTH. about 1857
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
45 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Rag buyer
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 84

9-BIRTHPLACE. (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER, ...

11-BIRTHPLACE OF FATHER, (State or Country). .....

12-MAIDEN NAME OF MOTHER, ...

13-BIRTHPLACE OF MOTHER, (State or Country). .....

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Curtis

(Address) 427 Druid Hill Ave

15-

Filed FEB 13 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 11, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) jury find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Feb 13 1923 (Address) 250 E Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	2/13 1923
20-UNDERTAKER.	ADDRESS
Samuel T Hensler	578 N Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72403

CERTIFICATE OF DEATH.

X 74-001

D72403

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 567 W. Biddle St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Wade Mc. Dow

(Residence in Baltimore: No. 567 W. Biddle St. St.; yrs. ..... mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	Single

6-DATE OF BIRTH. About 1859
(Month) (Day) (Year)

7-AGE. 32 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. actor
(b) General nature of industry, business, or establishment in which employed (or employer). 086

9-BIRTHPLACE, (State or Country). Tennessee.

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Saml. T. Hemsley

(Address) 578 W. Biddle St.

15-

Filed FEB 13 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 8, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hemsley M. D.
(Coroner.)

Feb. 13 1923 (Address) 280 Eutaw St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence. Tennessee

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	2/13 1923

20-UNDERTAKER. Saml. T. Hemsley ADDRESS 578 W. Biddle

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72404

CERTIFICATE OF DEATH.

75-00 D72404

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the St. 10 WARD)

2-FULL NAME. Ellen Fallon.

(a) RESIDENCE. NO. Preston & Patterson Park Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Michael Fallon.

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 70 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER John Collins.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant Little Sisters of the Poor.
(Address) Preston & Patterson Park Ave

15 Filed FEB 13 1923. 19 ROBERT R. KRABLER.
Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-12 1923

17

I HEREBY CERTIFY, That I attended deceased from 2-10 1923, to 2-12 1923, that I last saw h[illegible] alive on 2-11 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Senility

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr Bernard Lott, M. D.

2/12 1923 Address) 914 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: Feb 14 1923

20 UNDERTAKER: H. C. Wiedefeld

ADDRESS: 914 Greenmount Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72405

99-001

CERTIFICATE OF DEATH.

D72405

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 W Baltimore ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Modesa Smith

(a) RESIDENCE NO. 1722 W Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles J. Smith

6 DATE OF BIRTH (month, day, and year): July 2. 1852

7 AGE: Years 70 | Months 7 | Days 10 | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: William Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mistic Conn

12 MAIDEN NAME OF MOTHER: Hannah Heer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mistic Conn

14 Informant: Charles J. Smith

(Address): 1722 W Baltimore

15 Filed FEB 13 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1923, to Feb 12, 1923.

that I last saw her alive on Feb 11 1923,

and that death occurred, on the date stated above, at 2 45 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Cardiac weakness

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys. evidence

(Signed) J. C. Culbertson M. D.

2/12/23 (Address) 1901 Eutaw 14

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ft. Olivet Cem. DATE OF BURIAL: Feb. 14" 1923

20 UNDERTAKER: Joseph B. Cook ADDRESS: 1003 N. Balto St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72406

CERTIFICATE OF DEATH.

44 D72406

1-PLACE OF DEATH Church Home & Inf.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 23 WARD)

2-FULL NAME Mrs. Anna Rosenthal

(a) RESIDENCE NO. 1105 S Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Rosenthal

6 DATE OF BIRTH (month, day, and year) Oct 2nd 1861

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
61	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Fred J. Schleicher

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Bolle

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Bertha Rosenthal (Address) 1105 S Charles St.

15 Filed FEB 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11. 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1922, to Feb 11, 1923.

that I last saw her alive on Feb 11, 1923,

and that death occurred, on the date stated above, at 5-20 Am.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Dec 13 1922

Was there an autopsy? .....

What test confirmed diagnosis? Operation

(Signed) H. C. Kerr, M. D.

19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL 2/14/1923

20 UNDERTAKER E. J. Fanning & Son - 1938 E Lafayette Ave — ADDRESS

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72407

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72407

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1035 Ridgely St. St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsworth Elder.

(Residence in Baltimore: No. 1035 Ridgely St. St.; yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. Do not know. (Month) (Day) (Year)

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Pennsylvania.

PARENTS.

10-NAME OF FATHER. George W. Elder.

11-BIRTHPLACE OF FATHER, (State or Country). Pennsylvania.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Frank Smith.

(Address) 1033 Ridgely S t.

15- Filed FEB 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk. (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 11th. 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas poisoning.
Suicide.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Pennhardt M. D. (Coroner.)

Feb. 12. 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Freedom Pa DATE OF BURIAL. Feb 14 19..

20-UNDERTAKER. Lewis Dyster Sons ADDRESS New Freedom Pa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72408 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-80 D72408

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 W. Lexington St. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Jennie Kelly

(a) RESIDENCE NO. 1718 W. Lexington St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. Sybe How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 10 1858

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: nothing

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas Busk

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Harriett Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Nellie Beckardus

(Address) 618 W. Lexington St

15 FEB 15 1923 , 19 ROBERT M. CARUTH

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 12. 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, , 19 23, to Feb. 12, , 19 23,

that I last saw her alive on , 19 23

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Coolahan, M. D.

2/15, 19 23 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Feb 16 1923

20 UNDERTAKER: Josiah Leger — ADDRESS: 600 N. Mart

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72409

CERTIFICATE OF DEATH.

161-001 D72409

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Shakespheare ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME anthony Slawa

(a) RESIDENCE NO. 1612 Shakespheare ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph

6 DATE OF BIRTH (month, day, and year) Feb 6 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Michael Slawa

11 BIRTHPLACE OF FATHER (city or town) poland (State or country)

12 MAIDEN NAME OF MOTHER Agnes Domanska

13 BIRTHPLACE OF MOTHER (city or town) poland (State or country)

14 Informant Michael Slawa (Address) 1612 Shakespheare

15 FEB 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1923, to Feb 12, 1923, that I last saw h[illegible] alive on Feb 12, 1923 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia of right lung.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Total debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Voluntaro 6, M. D.

Feb 13, 1923 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Feb 13 1923

20 UNDERTAKER John M. Weber — ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72410 100-00 D72410

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Warner ST., 21 WARD)

2-FULL NAME Mary A. Cunningham

(a) RESIDENCE NO. 1216 Warner ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Cunningham

6 DATE OF BIRTH (month, day, and year) Jan 6-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ..... at home

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER John Swann

11 BIRTHPLACE OF FATHER (city or town) ..... Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) ..... Ireland
(State or country)

14 Informant Rev. Peter Cunningham

(Address) 1212 Warner St

B 137923 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb 9th, 1923, to Feb 11th, 1923, that I last saw her alive on Feb 11th, 1923 and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) ..... M. D.

Feb 12, 1923 (Address) 935 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb. 14 1923
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S Paca St

WHITE PENCIL, WITH CRAYON INK—THIS IS A PERMANENT RECORD. Every ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72411

CERTIFICATE OF DEATH.

D72411

REGISTERED No. C 129

1-PLACE OF DEATH 400 N. Fulton Ave Methodist Home for the Aged

CITY OF BALTIMORE: (No. ..... ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isabel F. Hughes

(Residence in Baltimore: No. Methodist Home for the Aged. St.; 60 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, March (Month) 7th (Day), 1842 (Year)

7-AGE, 80 yrs. 11 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or estsblishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Penna

PARENTS.

10-NAME OF FATHER, James Ferguson

11-BIRTHPLACE OF FATHER (State or Country), Penna

12-MAIDEN NAME OF MOTHER Eliza Williams

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Cuddy

(Address) 400 N. Fulton ave

15-

FEB 13 1923

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 12 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 15 1923, to February 12 1923, that I saw h er alive on February 11 1923, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) — yrs. — mos. 14 ds.

(Signed) Helen F. Hellmann M. D.

Feby 13, 1923 (Address) 127 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Febr. 14, 1923

20-UNDERTAKER George J. Smith

ADDRESS 1532 Holland

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72412 D72412

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2813 Hampden Ave St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Jane Blake

(Residence in Baltimore: No. 2823 Hampden 63 yrs St.: ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK. THE BLANKS MUST BE FILLED. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Mar 21 (Month), 1860 (Day) (Year)

7-AGE 62 yrs. 10 mos. 21 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER Michael Cavanaugh

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Not known

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Margaret Tuhey

(Address) 2813 Hampden Ave

15- FEB 13 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Feb 11 (Month) (Day), 1923. (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1922, to Feb 11 1923, that I saw her alive on Feb 11 1923, and that death occurred, on the date stated above, at 10 P M

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ?yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(Duration) yrs. 8 mos. ds.

(Signed) Roscoe Strose M. D.

Feb 12, 1923. (Address) 2438 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, Feb 14, 1923

20-UNDERTAKER Robt & Turner & Sons

ADDRESS 1414 Broadway

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72413 D72413

CERTIFICATE OF DEATH.

REGISTERED NO. 118-007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3004 Brighton ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Eugene Freeman

(a) RESIDENCE. NO. Charles Co. Md. ST., WARD Lothair, Chas. Co. Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) November 5 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Charles Co. Md.

PARENTS

10 NAME OF FATHER Zachariah Francis Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co. Md.

12 MAIDEN NAME OF MOTHER Mary Ann Farrall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co. Md.

14 Informant Edna Tyjsett

(Address) 3004 Brighton St

15 FEB 13 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 12 - 1923

17 I HEREBY CERTIFY, That I attended deceased from January 31, 1923, to February 13, 1923, that I last saw him alive on February 12, 1923, and that death occurred, on the date stated above, at 3:35 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) 23 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of heart

(duration) yrs. 3 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & symptoms

(Signed) Chester Riland, M. D.

2-12-1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lothair Station Md

DATE OF BURIAL 2/14 23

20 UNDERTAKER W. C. Cook

ADDRESS 6025 Nor

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72414

CERTIFICATE OF DEATH.

44 D72414

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 22 WARD)

2-FULL NAME John Mosedale

(a) RESIDENCE No. 245 Sharp St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lizzie Mosedale

6 DATE OF BIRTH (month, day, and year) 3 1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
57	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Mosedale

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 13 1923 Robert P. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from 12-22 1922 to 2-13- 1923, that I last saw h-- alive on 2-12- 1923, and that death occurred, on the date stated above, at 3:00 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Obstruction to Gastro-intestinal tract (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of Throat

(Signed) W. P. Orr. M. D.

2-13-1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Abington Md

DATE OF BURIAL 2/15 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 N Wat

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72415

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D72415

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2329 Mount ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto Urban Jr

(a) RESIDENCE NO. 2329 Mount ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 8 mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Otto Urban

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Hilda Neuman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant (Address) 2329 Mount

15 Filed 1923 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 11 1923 to Jan 13 1923.

that I last saw h alive on Jan 13 1923.

and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. O. Ryan M. D.

1923 (Address) 1 S Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Valley Memorial Park

DATE OF BURIAL 1/14 1923

20 UNDERTAKER Wm Cook

ADDRESS Govans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-13 1923

Spec.—1-10-21—M&T—1500 Bks.

D72416

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72416

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3715 Gough ST., 76 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Pauza

(a) RESIDENCE NO. 3715 Gough ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 27 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jan 19-1923

7 AGE: Years ..... Months ..... Days 27 If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER America Pauza

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Trillo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant America Pauza (Address) 3715 E. Gough St

15 FEB 13 1923 Robert P. Harrison, .19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1923, to Feb 12, 1923, that I last saw h[illegible] alive on Feb 11, 1923 and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Maxwell L. Mazer, M. D.

2/17/23 (Address) 311 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem — DATE OF BURIAL Feby 13 1923

20 UNDERTAKER John Ellerick — ADDRESS 2008 Aisquith

FEB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72417

CERTIFICATE OF DEATH.

D72417

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3817 E. Pratt St. (ST.,) 76 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luigi Tibruzi

(a) RESIDENCE NO. 3817 E. Pratt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 15-1921

7 AGE: Years 1 Months 9 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Dominic Tibruzi

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Mary Rotunda

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy.

14 Informant (Address): Dominic Tibruzi 3817 E. Pratt St.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

FEB 13 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1923, to Feb 12, 1923

that I last saw h[illegible]alive on Feb 12, 1923

and that death occurred, on the date stated above, at 9.35 a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Ruptured appendix

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Maxwell L. Magee M. D.

(Address) 3110 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. St Anislaus Cem

DATE OF BURIAL: Feb 14 1923

20 UNDERTAKER: Lilly and Zeiler.

ADDRESS: 403 S. Wolfe St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72418

CERTIFICATE OF DEATH.

117

D72418

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo E. Stifler

(a) RESIDENCE. No. 2501 Frances ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, ~~widowed or divorced~~ HUSBAND of (or) ~~WIFE~~ of Margaret O. Stifler

6 DATE OF BIRTH (month, day, and year) Oct. 17 1863

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
59	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co Md

PARENTS

10 NAME OF FATHER: Hiram Stifler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co. Md

12 MAIDEN NAME OF MOTHER: Matilda Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co Md

14 Informant: Margaret O. Stifler

(Address) 2501 Frances St

15 Filed FEB 13 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 13 1923

17 I HEREBY CERTIFY, ~~That~~ I attended deceased from Feb 7/23, 19.., to Feb 13/23, 19.., that I last saw ~~him~~ alive on Feb 11/23, 19.., and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of Feb 7/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B. Mohler, M. D.

FEB 13 1923 19.. (Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmerton, Harford Co Md

DATE OF BURIAL: FEB 15 1923

20 UNDERTAKER: Geo W Little

ADDRESS 2700 EDMONDSON AVE

FEB 13 1923

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

161164
D72419

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72419

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 21 WARD)

2-FULL NAME Ralph Moliano.

(a) RESIDENCE NO. 929 Ramsey St. City ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~(or) WIFE of~~ Ralph Moliano, (Father),

6 DATE OF BIRTH (month, day, and year) Dec. 16, 1918.

7 AGE: Years 4 Months 1 Days 24 — If LESS than 1 day, hrs. or ..min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Balto (Maryland)

PARENTS

10 NAME OF FATHER: Ralph Molinano.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Angelia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: JOHNS HOPKINS HOSPITAL

(Address): Records.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1923. to Feb. 12, 1923.

that I last saw him alive on Feb. 12, 1923.

and that death occurred, on the date stated above, at 7:47 A. m.

The CAUSE OF DEATH* was as follows:

Acute primary pneumonia (lobar)

(duration) yrs. mos 27 ds.

CONTRIBUTORY (Secondary): Primary

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. A. Veech M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: 2/14/23 19

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Harford Ave

B 13123

REGISTRATION DISTRICT NO. 1—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72420

133 D72420

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 16 WARD)

2-FULL NAME Edward James Journey

(a) RESIDENCE NO. 914 Monroe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret A. Journey

6 DATE OF BIRTH (month, day, and year) Feb. 15, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Savage (State or country) Howard County.

PARENTS

10 NAME OF FATHER Richard Journey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Mary Cross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Margaret A. Journey

(Address) 918 N. Monroe St

15 Robert P. Harrison, .19 Registrar

FEB 13 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 27 .1923. to Feb 12 .1923.

that I last saw him alive on Feb 11 .1923.

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Cystostomy (for retention due to prostatic hypertrophy)

(Duration of Hypertrophy 2 years +)

(Cystostomy (duration) yrs. mos. 5 ds.)

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb. 7, 1923

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R B Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Feb 15 1923

20 UNDERTAKER Jos Joerdens & Son — ADDRESS 217 S. Paca St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72421

D72421

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hosp. (ST.:) 6 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Griffin

(a) RESIDENCE. NO. 1824 Orleans St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. A. Griffin

6 DATE OF BIRTH (month, day, and year) July 12 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	6	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) James P. Griffin 1824 Orleans St.

15 Filed FEB 13 1923 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1922 to Feb. 11, 1923, that I last saw h[er] alive on Feb. 10, 1923, and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Uterus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) S. W. Kourey, M. D.

2/11, 1923 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents Cemetery

DATE OF BURIAL 2/14" 1923

20 UNDERTAKER Chas F. Eoane & Son

ADDRESS 1180 Mont Royal ave

FEB 13 1923

INSTRUCTIONS.—PLEASE PRINT WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72422

CERTIFICATE OF DEATH.

90~ D72422

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 808 S. Fremont ST., 21 WARD)

2-FULL NAME Frederick J. Bowers

(a) RESIDENCE NO. 808 S. Fremont ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Bowers

6 DATE OF BIRTH (month, day, and year) April 17 1859

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
63	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Harper & Dulin

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Martin H. Bowers

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Mayer Brula

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Clara

(Address) 808 S. Fremont

FEB 13 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1923, to Feb 13, 1923, that I last saw him alive on Feb 13, 1923, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.

not known (duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) John A Buchness, M. D.

, 19 (Address) 650 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Feb 16 23

20 UNDERTAKER Wm Pickup & Sons ADDRESS Norfolk Va

S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1560 Bks.

D72423

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002 D72423

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1137 Woodley St., 16 (Ward)

2-FULL NAME Susan Dorsheck

(a) RESIDENCE NO. 1137 Woodley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James H. P. Dorsheck

6 DATE OF BIRTH (month, day, and year): May 2 1853

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
69	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Henry Little

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Decker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Ruth M Ritz

(Address): 1137 Woodley St.

15 Filed FEB 13 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1923, to Feb 11, 1923, that I last saw h[illegible] alive on Feb 11, 1923, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chron. Bronchitis & Emphysema.

Unknown (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. C. Conser, M. D.

2/11, 1923 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL 19

20 UNDERTAKER: Wm Peckrue Sr. — ADDRESS Norfolk Va

P.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72424

11-607

D72424

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2413 Gilford ave ST., 17 WARD)

2-FULL NAME Sarah E. Preston

(a) RESIDENCE NO. 2413 Gilford ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Preston

6 DATE OF BIRTH (month, day, and year) July 24 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Wm H. Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bucks Co. Pa.

12 MAIDEN NAME OF MOTHER Sarah A. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md.

14 Informant (Address) Mrs. Walter Pearce 2413 Gilford Ave.

15 FEB 13 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22 1922 to Feb. 12 1923.

that I last saw her alive on February 12 1923.

and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Septic myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Geo. M. Shyrock M. D.

1923 (Address) 1 & 3 W Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friendship Cemetery Harford Co. DATE OF BURIAL Feb 14 1923

20 UNDERTAKER Wm J. Tucker & Son ADDRESS Md

FEB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72425

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72425

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris M. Mauger

(a) RESIDENCE NO. 107 Augusta Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) ~~Married~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Dec. 29-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1 yrs	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Mauger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. ~~Do not know~~

12 MAIDEN NAME OF MOTHER Hazel V. Emmett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Mauger

(Address) 107 Augusta Ave

15 Filed 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1923, to Feb. 12, 1923.

That I last saw h[illegible] alive on Feb. 12 1923

and that death occurred, on the date stated above, at 12 40 P m.

The CAUSE OF DEATH* was as follows:

Broncher pneumonia.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St Agnes.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Feby 14 1923

20 UNDERTAKER Elmer V. Conklin

ADDRESS 924 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

13 1923

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Blks.

160 2 D72426

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72426

CERTIFICATE OF DEATH.

X 31

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. 7 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Noah Coley

(a) RESIDENCE NO. Wilson, N. C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 months ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 24-1884

7 AGE — Years: 38 — Months: 5 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Joseph Coley

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Mary J. Mincture

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

Feb 13 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13. 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1923, to Feb 13, 1923, that I last saw him alive on Feb 13, 1923, and that death occurred, on the date stated above, at 5 PM m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, genital tract, Kidneys, & Lungs

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes, Date of Dec 30. 1922

Was there an autopsy? yes OWN

What test confirmed diagnosis? Autopsy

(Signed) J. P. Johnston, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wilson N. C. DATE OF BURIAL: Feb 13 1923

20 UNDERTAKER: Joseph Sykes ADDRESS: 21 Bundy

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Left Nephrectomy.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D72427

CERTIFICATE OF DEATH.

D72427

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Minnie Polsky

(a) RESIDENCE NO. 215 S. Caroline St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 15 yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Landsman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russian

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Polsky (Address) 215 Caroline St

15 FEB 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1923, to Feb. 13, 1923,

that I last saw her alive on Feb. 13, 1923,

and that death occurred, on the date stated above, at 12 noon m/

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (terminal).

Cerebral Hemorrhage

(duration) yrs. mos 2½ ds.

CONTRIBUTORY (Secondary) Gen. Arteriosclerosis & Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? C

(Signed) Morris Seleman, M. D.

Feb. 13, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 2/13 1923

20 UNDERTAKER Maf Levinson

ADDRESS 1127 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

D72428

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72428

CERTIFICATE OF DEATH.

100-001

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 Moale St. ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm E. Simmons

(a) RESIDENCE NO. 26 Moale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 6 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John A. Simmons

11 BIRTHPLACE OF FATHER (city or town) Taylors Island (State or country) Md.

12 MAIDEN NAME OF MOTHER Virginia Honor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John A. Simmons (Address) 26 Moale St.

15 Filed FEB 14 1923 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1923, to Feb 13, 1923, that I last saw h[illegible] alive on Feb 13, 1923, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia (Primary)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell M. D.

Feb 13, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Feb 13 1923

20 UNDERTAKER: John J. Fulton — ADDRESS: 1200 W. Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72429

CERTIFICATE OF DEATH.

D72429

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Palmico Road & Ridgley Ave ST., WARD)

2-FULL NAME Annie Righter

(a) RESIDENCE No. Palmico Road & Ridgley Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Maurice R. Righter

6 DATE OF BIRTH (month, day, and year): Sept 18-1887

7 AGE: Years 35 Months 4 Days 24 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Delaware

PARENTS

10 NAME OF FATHER: John E. Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto City

12 MAIDEN NAME OF MOTHER: Emma E. Muir

13 BIRTHPLACE OF MOTHER (city or town) (State of country): Delaware

14 Informant: J. E. Robinson (Address) Palmico Rd & Ridgley Ave

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12th 8 AM 1923 to Feb. 12th 4.45 PM 1923, that I last saw her alive on Feb. 12th 1923, and that death occurred, on the date stated above, at 4:46 P— m.

The CAUSE OF DEATH* was as follows:

Epileptic Convulsions

Coverng Period of 5 years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilitation 12 hours

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes. Clinical

What test confirmed diagnosis?

(Signed) O. R. Wantz M. D.

Feb 13 1923 (Address) 865 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Feb 14 1923

20 UNDERTAKER: A. S. Marshall — ADDRESS: 3537 Falls

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72430

CERTIFICATE OF DEATH.

90 D72430

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 199 Fall Road (ST.,) W Roland Park (WARD) 27

2-FULL NAME Lydia Agnes McKenny

(a) RESIDENCE No. 199 Fall Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Martin L. McKenny

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 57; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Servant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co

PARENTS

10 NAME OF FATHER: Rev. Edward Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Henrietta Perkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co. Md

14 Informant: Rev. N. McKenny

(Address): 199 Fall Road

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/17 19 23

17 I HEREBY CERTIFY, That I attended deceased from 2/1, 19 23, to 2/17, 19 23, that I last saw h~ alive on 2/17, 19 23, and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration due to valvular disease

of 4 Years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Congestion Lobe (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Henry T Carey, M. D.

, 19 (Address) 1 Replevo Ct.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St John Church Baltimore — DATE OF BURIAL: Feb 15 19 23

20 UNDERTAKER: A S Marshall — ADDRESS: 353 Fall Rd.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72431

CERTIFICATE OF DEATH.

162 D72431

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby King

(a) RESIDENCE NO. 2120 Ashland ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) Feb. 4, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	Age	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Marie Jira

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital.

15 FEB 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/12/23 19

17

I HEREBY CERTIFY, That I attended deceased from 2/9/23, 19, to 2/12/23, 19,

that I last saw him alive on 2/12/23, 19,

and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings.

(Signed) Harry Wade, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL Feb 14 1923

20 UNDERTAKER Frank Groetzinger ADDRESS Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

New Born

Breech Presentation

Spec.—6-9-19—H. P. Co.—1000 Rks.

D72432

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 D72432

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2819 Mosher St ST.; 16 WARD)

2-FULL NAME Mary McLaughlin

(a) RESIDENCE. NO. 2819 Mosher ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Henry McLaughlen

6 DATE OF BIRTH (month, day, and year) Jan 10, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thos Mannion

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant C. J. Gorman

(Address) 2819 Mosher St

15 FEB 14 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 12, 1923, that I last saw her alive on Feb 12, 1923, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 13 hours

CONTRIBUTORY (Secondary) Acute Rheumatism

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) W. J. Costello, M. D.

, 19 (Address) 336 E 31st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	2/15 20
20 UNDERTAKER	ADDRESS
H. C. Brauning & Son	517 N. Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D72433

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 23 WARD)

2-FULL NAME Henry Dashields

(a) RESIDENCE No. 213 N. Hamburg st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Dashields

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Chase

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address) M. T. H.

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1922, to Feb. 9, 1923,

that I last saw him alive on Feb. 9, 1923,

and that death occurred, on the date stated above, at 7.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Steuart L. Pratt M. D.

2-10-23, 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Feb 14 1923
20 UNDERTAKER	ADDRESS
Jos. N. Joachim	1402 Lexington St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72434

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 D72434

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 Tyson ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Rench

(a) RESIDENCE. NO. 429 Tyson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Agnes Bynum
(Address) 429 Tyson St

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1922, to Feb 12, 1923

that I last saw h alive on Feb 11, 1923

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows: Chronic Gastritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Ca Stomach

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. H. Fleder M. D.

Feb 13 1923 (Address) 714 E. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Feb 14 1923
20 UNDERTAKER	ADDRESS
J. W. H. Loadenthal	1412 W. Baltimore St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Alcoholisme

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72435

REGISTERED NO.

N. B.—WRITE PLAINLY, with unfading ink—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 793 N Saratoga ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Lloyd

(a) RESIDENCE. NO. 793 N Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Stephen Graves

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Chas Bane
(Address) 793 N Saratoga St

15 FILED FEB 14 1923 ROBERT R. KRAUER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1922, to Feb 10, 1923, that I last saw h alive on Feb 10, 1923, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Feb, 19 23 (Address) 439 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Feb 14 1923

UNDERTAKER [redacted] Wheeley

ADDRESS 1325 Biddle St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72436 HEALTH DEPARTMENT--CITY OF BALTIMORE Weeks

CERTIFICATE OF DEATH

101-001

D72436

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 523 Mc Mechen St. WARD) (If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Sadie Meeks

(Residence in Baltimore: No. 523 Mc Mechen St St.: 8 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6 DATE OF BIRTH: Sept (Month) 12 (Day), 1890 (Year)

7 AGE: 32 yrs. 4 mos. 30 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Tolbert Co. Miss

PARENTS

10 NAME OF FATHER: Lloyd T. Sherwood

11 BIRTHPLACE OF FATHER (State or country): Miss

12 MAIDEN NAME OF MOTHER: Julia Trigg

13 BIRTHPLACE OF MOTHER (State or country): Miss

14 I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Meeks

(Address) 523 Mc Mechen St

15

FEB 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 2 (Month) 11 (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1923, to Feb 11 1923

that I saw h[illegible] alive on Feb 11, 1923

and that death occurred, on the date stated above, at 1.40 P m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (SECONDARY): Infection & Obesity

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Feb 14 1923 (Address) 1202 Hull St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Feb 15 1923

20 UNDERTAKER: Samuel Deardorff

ADDRESS: 1[illegible] Biddle St

Spec. 6-9-19 H. P. Co. 1000 Blks.

D72437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D72437

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2105 Saratoga St. (Mt. Winans) ST.: WARD)

2-FULL NAME Harry Blocker

(a) RESIDENCE. No. 2105 Saratoga ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Mar 1st 1898

7 AGE — Years: 24 — Months: 11 — Days: 11 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Boiler washer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): S. Carolina

PARENTS

10 NAME OF FATHER: Jackson Blocker

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. Carolina

12 MAIDEN NAME OF MOTHER: Carrie Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. Carolina

14 Informant (Address): Carrie Blocker Mt Winans

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/11 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/20/ 1923 to 2/11/ 1923 that I last saw h[im] alive on 2/10/ 1923 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T B.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum Exam.

(Signed) J. B. Hawkins, M. D.

1916 S. H. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Feb 15 1923

20 UNDERTAKER: Samuel Hemsley

ADDRESS: Middle St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D72438

CERTIFICATE OF DEATH.

66 D72438

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 811 Fawn ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. H. Trusty (Trusly)

(Residence in Baltimore: No. 811 Fawn St.; Life yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should study CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Color

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, November (Month) 1 (Day) (Year)

7-AGE. 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer): Tailoring Ind.

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Aron Trusty

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER June

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. H. Trusty

(Address) 1061 Gatewood Ave

15- Filed FEB 14 1923, 191... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb. 11th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 26th 1922, to Feb 11th 1923, that I saw h[im] alive on Feb 10th 1923 and that death occurred, on the date stated above, at 1.10 P.M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart due to

Influenza (Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Contributory

(Duration) 2 yrs. 1 mos. 7 ds.

(Signed) A. Lee Ehrs M. D.

Feb 14, 1923 (Address) 92 W. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, Feb. 14 1923

20-UNDERTAKER Samuel Hensley & Bro. ADDRESS 578 W. Baltimore St.

Remarks Accidental

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72439

CERTIFICATE OF DEATH.

D72439

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 917 N. 10th St. (Orangeville) ST., WARD)

2-FULL NAME John Charles

(a) RESIDENCE No. 917 N. 10th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Charles

6 DATE OF BIRTH (month, day, and year) April 22, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 11 years

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Henry Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Mary Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant J. K. Bryan (Address) 917 N. 10th St

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 10 1923, to Feby 12 1923, that I last saw h/m alive on Feby 12 1923 and that death occurred, on the date stated above, at 2 15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency Hypertension (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis (duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edgar W. Miller M. D.

Feby 14 1923 (Address) 1008 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Feb 15 1923

20 UNDERTAKER H. Sander Sons ADDRESS 1110 Park

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Heinze

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72440

CERTIFICATE OF DEATH.

118 D72440

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Heinze

(a) RESIDENCE NO. 727 So. Luzerne Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick A. Heinze

6 DATE OF BIRTH (month, day, and year) Sept 11, 1877

7 AGE: Years 45 | Months 5 | Days 2 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0.37

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Karl Heiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mina Bellman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Frederick A. Heinze

(Address) 227 S. Luzerne Ave

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-13-1923

17

I HEREBY CERTIFY, That I attended deceased from 2-7-, 1923, to 2-13-, 1923.

that I last saw h alive on 2-13-, 1923

and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction due to adhesions

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/7/23

Was there an autopsy? Yes

What test confirmed diagnosis? Op. findings

(Signed) Newton D. Baker, M. D.

2/13, 1923 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: 1st Evangelical Cem. DATE OF BURIAL: Feb. 16 1923

20 UNDERTAKER: H. Sander Sons ADDRESS: 1710 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

For the obstruction.

Spec.—1-10-21—M&T—1500 Bks.

D72441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D72441

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 S Potomac ST., 1 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Muhlenfeld

(a) RESIDENCE No. 35 S Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Muhlenfeld

6 DATE OF BIRTH (month, day, and year) Feb 29 1830

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Foreman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George W. Muhlenfeld (Address) 35 S Potomac St

15 Filed FEB 14 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9 1923 to Feb 11 1923

that I last saw h— alive on Feb 11 1923

and that death occurred, on the date stated above, at 9.45 P. m

The CAUSE OF DEATH* was as follows:

Acute Bronchs - Pneumonia

(La Grippe)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Senility - (Contracted at Vassalas Dep.) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Found

(Signed) M. A. Bonner, M. D.

, 19 (Address) 1250 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Cem. DATE OF BURIAL Feb 14 1923

20 UNDERTAKER H. Sander Son ADDRESS 1710 Pink

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72442

CERTIFICATE OF DEATH.

100-001

D72442

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2332 Stockton ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Abrams

(a) RESIDENCE. No. 2332 Stockton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 24, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Agustus Abrams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Irene E. Durham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs. Irene Abrams
(Address) 2332 Stockton St

15 FILED FEB 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1923, to Feb. 12, 1923, that I last saw h[illegible] alive on Feb 12, 1923, and that death occurred, on the date stated above, at 4.10 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & symptoms

(Signed) John E. Lemmer, M. D.

, 19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville — DATE OF BURIAL: Feb. 14 1923

20 UNDERTAKER: [illegible] — ADDRESS: 313 Woodbourne

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

Diggs

D72443 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D72443

11-002

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 N. Lafayette ST., 16 WARD)

2-FULL NAME Amanda Diggs

(a) RESIDENCE NO. 1304 N Lafayette ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

WARNING—RESERVED FOR BIRTHS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Howard Diggs

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: 45 (Years / Months / Days) — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 10
(c) Name of employer: Garfield

9 BIRTHPLACE (city or town) (State or country): Garfield Md.

PARENTS

10 NAME OF FATHER: George Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Garfield Md.

12 MAIDEN NAME OF MOTHER: Caroline Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ella Gibson
(Address): 1304 N. Lafayette Ave

15 Filed FEB 14 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-12 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-11-23, 1923, to 2-12-, 1923
that I last saw her alive on 2-12-, 1923
and that death occurred, on the date stated above, at 7:00 P. m.
The CAUSE OF DEATH* was as follows:
Pneumonia

(duration) .... yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Debility, Old age (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? ....
Did an operation precede death? no Date of ....
Was there an autopsy? no
What test confirmed diagnosis? ....

(Signed) T. W. Cardozo, M. D.
, 19 (Address) 524 N. Pitt ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Feb. 15 1923

20 UNDERTAKER: James A. Lund — ADDRESS: 203 Baltimore

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72444

CERTIFICATE OF DEATH.

100-001

D72444

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 Clarkson ST. 23 WARD)

2-FULL NAME Gerald D. Gill

(a) RESIDENCE NO. 1738 Clarkson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 15, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Gill

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Anna Rehm

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Mrs. Anna Gill
(Address) 1738 Clarkson St.

15 Filed FEB 14 1923 ROBERT R. KRAUTH (Registrar)
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 12, 1923, that I last saw h[illegible] alive on Feb 12, 1923, and that death occurred, on the date stated above, at [illegible] P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
Primary

(duration) ..... yrs. ..... mos 12 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M.D. R. Campbell, M. D.

Feb 13, 1923 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Feb. 14, 1923

20 UNDERTAKER Margaret J. Flynn ADDRESS 1422 Light St.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72445

CERTIFICATE OF DEATH.

11 2 D72445

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1407 E Biddle ST., 10 WARD)

2-FULL NAME Erin Rogan

(a) RESIDENCE NO. 1407 E Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, ~~or Divorced~~, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 13 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	~~4 mo~~			
	~~4 Wk. 13~~	3	—	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leon Rogan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jenette Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Leon Rogan
(Address) 1407 E. Biddle

15 FEB 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/23.

17 I HEREBY CERTIFY, That I attended deceased from 1-24-, 1923, to 2-13-, 1923,

that I last saw h~~im~~ alive on 2-13-, 1923,

and that death occurred, on the date stated above, at 12 ~~m~~.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Pyloric Stenosis

(duration) yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Harry Goldring, M. D.

2/13, 1923 (Address) 2210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Druid Ridge Cem

DATE OF BURIAL Feb 14 1923

20 UNDERTAKER Jacob Levin

ADDRESS 1439 E Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D72446

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1923 D72446

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 Woodbourne St. 27 WARD)

2-FULL NAME Catherine Murphy

(a) RESIDENCE NO. 531 Woodbourne ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick Murphy

6 DATE OF BIRTH (month, day, and year): 1/20/26

7 AGE: Years 87 Months Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Farley Kavanaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Do not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Kavanaugh

(Address) 5703 Oak Ave

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 3 1921 to Feb. 11 1923.

that I last saw h alive on Feb. 11 1923,

and that death occurred, on the date stated above, at 12- m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Haas, M. D.

2-12 1923 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Govans — DATE OF BURIAL: 2/14 1923

20 UNDERTAKER: A C Takeyama — ADDRESS: 1318 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72447

CERTIFICATE OF DEATH.

151

D72447

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 2 WARD)

2-FULL NAME Henry Peters

(a) RESIDENCE No. 919 Fell St. ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or State or country) Denmark

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-1st, 1923, to 2-13, 1923, that I last saw him alive on 2-13, 1923, and that death occurred, on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

Cellulitis of right foot & leg (Amputation of leg)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Gas gangrene

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Hospital Bay View

Did an operation precede death? Yes Date of 2/3/23

Was there an autopsy? Yes

What test confirmed diagnosis? Examination of part

(Signed) [illegible] M. D.

2-13-1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Private Cemetery	Feb 15 1923
20 UNDERTAKER Lilly & Zeich	ADDRESS 400 Mosher St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVES FOR SIGNING

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72448

CERTIFICATE OF DEATH.

31 D72448

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 E Madison ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie Ada Pulley

(Residence in Baltimore: No. 1531 E Madison St.; 14 yrs., ... mos. ..... ds.)

N. B.—THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK.
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	C	Married

6-DATE OF BIRTH, Oct (Month) 13 (Day), 1898 (Year)

7-AGE, 24 yrs. 3 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): D37

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John W. Goldsborough

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Laura Blake

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lawrence F. Pulley (husband)

(Address) 1531 E Madison st

15 FEB 14 1923 Filed ....., 191.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 11 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 1922, to Feb 11 1923, that I saw her alive on Feb 11 1923, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

..... (Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R J Young M. D.

2/12, 1923. (Address) 1424 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn	Feb 15, 1923
20-UNDERTAKER	**ADDRESS**
John W Henderson	1502 E Monument

D72449

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72449

CERTIFICATE OF DEATH.

4 X 38

Registered No. C.....

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. ..... St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Berry Stroud

(Residence in Baltimore: No. None 38 W 128th St New York St.; yrs. ..... mos. ..... ds.) (1 Hour)

PERSONAL AND STATISTICAL PARTICULARS.

Married

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
M.	C-	

6-DATE OF BIRTH. July (Month) 5 (Day) 1885 (Year)

7-AGE. 37 yrs. 7 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION. (a) Trade, profession, or particular kind of work: Railroad Waiter.
(b) General nature of industry, business, or establishment in which employed (or employer): 0120

9-BIRTHPLACE, (State or Country). N C.

PARENTS.

10-NAME OF FATHER. Berry Stroud.

11-BIRTHPLACE OF FATHER, (State or Country). N C.

12-MAIDEN NAME OF MOTHER. Dennis Lake.

13-BIRTHPLACE OF MOTHER, (State or Country). N C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert B. Stroud

(Address) 38 to 40 W. 137th St New York

15. FEB 14 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 10 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of Blood Vessels

(Duration) ..... yrs. ..... mos. ..... 1hr ds.

CONTRIBUTORY (Secondary) Shocks

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Chilton Pfaff M. D.
(Coroner)

Feb 14 1923 (Address) 143 N Bond

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Cary, Wake Co. N.C.	Febry 15 1923
20-UNDERTAKER JOHN A BISHOP & SON	ADDRESS 1107 Druid Hill Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Remarks. Autopsy by Dr. Mallett.

Monday Feb 12/23-

Probably Syphilis

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 2d *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia.*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72450

CERTIFICATE OF DEATH.

X 100-001

D72450

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp'l (St.) B (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister ~~Rosalyn~~ Rosalyn

(a) RESIDENCE. No. 3135 S. Broadway (St.) WARD.

(Usual place of abode)

Illinois

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10 NAME OF FATHER Pro Shea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire

12 MAIDEN NAME OF MOTHER Conlan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant P Rosalyn Shea (Address) Jesuit Fr

15 Filed FEB 14 1923 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1923, to Feb. 13, 1923, that I last saw her alive on Feb. 12, 1923, and that death occurred, on the date stated above, at 1 30 A.m.

The CAUSE OF DEATH was as follows:

Bronchs Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Auricular Fibrillation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) John J Kluger M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	2/15/ 19
20 UNDERTAKER	ADDRESS
J G Moran	3305 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D72451

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1846 N. Collington Ave ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME — Ann M. Fischer

(a) RESIDENCE. No. 1846 N. Collington Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. One ds How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 11th 1923

7 AGE — Years — Months — Days: One — If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Fischer.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Margaret Suder.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: John Fischer
(Address): 1846 N. Collington ave

15 FILED FEB. 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12th 19 23

17

I HEREBY CERTIFY, That I attended deceased from February 11th, 19 23, to February 11th, 19 23, that I last saw her alive on February 11th, 19 23, and that death occurred, on the date stated above, at 9 50 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Conrad Bar, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Feb 14 1923

20 UNDERTAKER: Richard F. Cauley — ADDRESS: 458 S. Wolfe ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D72452

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D72452

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 244 London ST. 4th WARD)

2-FULL NAME Mary E. Hock

(a) RESIDENCE No. 279 London ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Jacob Hock

6 DATE OF BIRTH (month, day, and year) March 12 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Conrad Sproll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sarah Hock

(Address) 244 London

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-13 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2- 1923, to Feb 12 1923, that I last saw h[illegible] alive on Feb 12 1923 and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Carried

(Signed) Willis Hennig, M. D.

2/13 1923 (Address) 2000 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 2/16 1923

20 UNDERTAKER W. W. Cook

ADDRESS 502 11th

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72453

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72453

CERTIFICATE OF DEATH.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 South Sharp ST., 23 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Becker

(a) RESIDENCE NO. 1004 S. Sharp ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Married~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Becker

6 DATE OF BIRTH (month, day, and year): July 25-1872

7 AGE — Years: 50 — Months: ... — Days: ... — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Maine

PARENTS

10 NAME OF FATHER: Mason S. Spurr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maine

12 MAIDEN NAME OF MOTHER: Sarah C. Spurr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maine

14 Informant: Wm Becker
(Address): 1004 S. Sharp

15 FEB 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-13-1923

17 I HEREBY CERTIFY, That I attended deceased from January 18, 1923, to Feb 13, 1923, that I last saw her alive on Feb 13, 1923, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB

(duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Shepherd Davis, M. D.

, 19 (Address) 1000 Eutaw Co Bk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 2/16 1923

20 UNDERTAKER: W R Cook Co — ADDRESS: 502 Cath

Spec.—1-10-21—M&T—1500 Bks.

Jno H Engles ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72454

CERTIFICATE OF DEATH.

24-001 D72454

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1246 James ST. 21 WARD)

2-FULL NAME Jno H Engles

(a) RESIDENCE NO. 1246 James ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Caroline Engles

6 DATE OF BIRTH (month, day, and year) Sept. 5 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69		5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Engles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Elmer Engles
(Address) 2141 W. Saratoga St.

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-11 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to Feb 11, 1923, that I last saw h[illegible] alive on Feb 11, 1923, and that death occurred, on the date stated above, at 110 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Asthma (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Bowen, M. D.

, 19 (Address) 306 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Feb. 14 1923

20 UNDERTAKER Harry J. Hitzke

ADDRESS 1531 N Eutaw St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72455

CERTIFICATE OF DEATH.

X36-005 D72455

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Irene ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Octavius W. Risley

(a) RESIDENCE NO. New York City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE: Years 60; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Theatrical Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Wilmington N.C.

PARENTS

10 NAME OF FATHER Richard A. Risley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Emily Sargent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Mrs. Harry M. Stein

(Address) 1315 Mt. Royal Ave

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13 1923.

17 I HEREBY CERTIFY, That I attended deceased from 1/27, 1923, to 2/13, 1923, that I last saw h[illegible] alive on 2/13, 1923, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Ostritis of Lumbar Vertebrae

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? outside

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) Iron Wreden, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Feb 15 1923

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1531 Lombard St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72456

CERTIFICATE OF DEATH.

31 D72456

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 14 WARD)

2-FULL NAME Richard Murray

(a) RESIDENCE No. 1426 McCullough St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	49	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Murray

11 BIRTHPLACE OF FATHER (city or town) Chestertown, (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Chestertown (State or country) Maryland

14 Informant Municipal Hospital Records. (Address)

15 FEB 14 1923 ROBERT N. KRAUTER, (Registrar) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1923

17

I HEREBY CERTIFY, That I attended deceased from February 11, 1923, to February 12 1923, that I last saw him alive on February 11, 1923, and that death occurred, on the date stated above, at 6:50 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Clyde Mitchell, M. D.

2-13-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkton	Feb 15 1923

20 UNDERTAKER Samuel Wright ADDRESS 2564 Mary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72457

CERTIFICATE OF DEATH.

D72457

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3008-N-Calvert-St. ST., 12 WARD)

2-FULL NAME Roxanne Tatman Goodrich

(a) RESIDENCE NO. 3008-N-Calvert-St. ST., 12 WARD (Resident)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ? mos. ?. ds. How long in U. S., if of foreign birth? 74 yrs. 6 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marcellus Hamilton Goodrich.

6 DATE OF BIRTH (month, day, and year) July-16-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Columbia (State or country) Indiana.

PARENTS

10 NAME OF FATHER William Tatman

11 BIRTHPLACE OF FATHER (city or town) GloucesterCo (State or country) Virginia

12 MAIDEN NAME OF MOTHER Polly Blake

13 BIRTHPLACE OF MOTHER (city or town) GloucesterCo (State or country) Virginia

14 Informant H. B. Flowers (Son-inlaw)

(Address) 3008-N-Calvert-St., City

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13 1923

17

I HEREBY CERTIFY, That I attended deceased from 10/1, 1922, to 2/13, 1923.

that I last saw h alive on 2/12, 1923

and that death occurred, on the date stated above, at 10.55 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis, Angina Pectoris

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Irwin C. Padgett, M. D.

2/13, 1923 (Address) 805 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
DRUID RIDGE CEMETERY	Feb-15-23

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT mation should be carefully supplied. AGE should be stated EXACT CAUSE OF DEATH in plain terms, so that it may be properly classified TION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDI

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72458

REGISTERED NO. 90 D72458

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603-Madison-Av. ST., 14 WARD)

2-FULL NAME Dr. William Caspari

(a) RESIDENCE NO. 1603-Madison-Av. ST., 14 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 2 mos. 26 ds. How long in U. S., if of foreign birth? 61 yrs. 2 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Baden Caspari

6 DATE OF BIRTH (month, day, and year) Nov-18-1861

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physcian

(b) General nature of Industry, business, or establishment in which employed (or employer) Medicine

(c) Name of employer (self)

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William Caspari

11 BIRTHPLACE OF FATHER (city or town) Hanover (State or country) Germany

12 MAIDEN NAME OF MOTHER Alvine Hunsius

13 BIRTHPLACE OF MOTHER (city or town) Hanover (State or country) Germany

14 Informant Mrs. Mary B. Caspari, (wife) (Address) 1603-Madison-Av., City.

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1923, to Feb 13, 1923, that I last saw h[illegible] alive on Feb 13, 1923, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

2 hours (duration)

CONTRIBUTORY (Secondary) Coronary sclerosis & myocarditis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Joseph Eichner, M. D.

Feby, 19 (Address) 1516 Madison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Feb-17 23

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS' mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72459

CERTIFICATE OF DEATH.

X 100-601

D72459

REGISTERED NO.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belvedere Hotel ST., [redacted] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Warfield Hoopes

(a) RESIDENCE No. Belvedere Hotel ST., II WARD West Chester Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. I4 ds. How long in U. S., if of foreign birth? 60 yrs. 9 mos. I5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Hoopes

6 DATE OF BIRTH (month, day, and year) Apr. 30 I862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60	9	I5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Howard County Md.

PARENTS

10 NAME OF FATHER Albert G Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Margaret Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md.

14 Informant Mr. Edward Hoopes (Son)
(Address) West Chester Pa.

15 Filed FEB 14 1923 ROBERT R. KRAUTER, (Registrar) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1923, to Feb 13, 1923, that I last saw h[illegible] alive on Feb 13, 1923, and that death occurred, on the date stated above, at 11-45 P m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac-Weakness

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? In Baltimore Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. D. Atkinson, M. D.

Feb 14, 1923 (Address) 1010 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Chester Pa.

DATE OF BURIAL Feb-14-23

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODRUM, Successor)

ADDRESS 108 W. NORTH AVE.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72460

CERTIFICATE OF DEATH. X 100-001

D72460

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belvedere Hotel ST., 11 WARD)

2-FULL NAME Herman Hoopes

(a) RESIDENCE NO. Belvedere Hotel ST., 11 WARD West Chester Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? 68 yrs. 7 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret W. Hoopes

6 DATE OF BIRTH (month, day, and year) June 29-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Insurance 86
(b) General nature of industry, business, or establishment in which employed (or employer) Insurance Agent
(c) Name of employer Fidelity & Deposit Co West Chester Penna

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Edw. Hoopes
11 BIRTHPLACE OF FATHER (city or town) West Chester (State or country) Penna
12 MAIDEN NAME OF MOTHER Guilelma Townsend
13 BIRTHPLACE OF MOTHER (city or town) West Chester (State or country) Pa.

14 Informant Mr. Edward Hoopes (Son)
(Address) West Chester Pa.

15 FEB 14 1923 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 5 1923, to Feb 14 1923, that I last saw h[illegible] alive on Feb 14 1923, and that death occurred, on the date stated above, at 10-45 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Cardiac Weakness (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? In Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? — Clinical

(Signed) E. O. Atkinson, M. D.

19 (Address) 1210 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
West Chester Pa.

DATE OF BURIAL Feb/14 1923

20 UNDERTAKER
STEWART & MOWEN COMPANY
(WILLIAM E. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

D72461 Sorrell ✓ HEALTH DEPARTMENT—CITY OF BALTIMORE 188-003 D72461

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. U. F. I. St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Walter J. Sorrell

(Residence in Baltimore: No. 2110 McCulloh St. 60 St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	Colored	married

6-DATE OF BIRTH. about (Month) (Day) 1863 (Year)

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer) 186

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Walter Sorrell

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Eliz. Weaver

13-BIRTHPLACE OF MOTHER, (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sophie Siddons

(Address) 1204 Argyle Ave.

15. Filed FEB 14 1923 192 ROBERT R. KRAMER, Burial Permit Clerk. (Name of Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 10 (Month) (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an unquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said unquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Patella

about 2 months (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) automobile accident

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner)

Feb. 14 192 3 (Address) 220 Cathedral St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL. 2/14 1923

20-UNDERTAKER. John H Toadvin — ADDRESS 1097 Hanover

Spec.—8-24-14—M. & T.—2000 Blks.

Bathon

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72462

CERTIFICATE OF DEATH.

162 D72462

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cherry Hill ST.; 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred G Bathon

(Residence in Baltimore: No. Cherry Hill old annapolis Road St.; ..... yrs., ... mos. 12 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, 2 (Month) 1 (Day), 1923 (Year)

7-AGE, ... yrs. ..... mos. 12 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Cherry Hill old annapolis Road

PARENTS.

10-NAME OF FATHER, Edw J. Bathon

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Josephine C Sanders

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw J. Bathon

(Address) Cherry Hill Westport

15- FEB 14 1923 191.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 12 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2 10 1923, to 2 12 1923, that I saw h[illegible] alive on 2 12 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Immediate infection

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary).....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm B Hall M. D.

2.14., 1923 (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Feb. 14, 1923

20-UNDERTAKER Fred A. Brauer & Son ADDRESS 703 Hanover

Spec.—1-10-21—M&T—1500 Bks.

D72463

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D72463

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 16 WARD)

2-FULL NAME George Sheets

(a) RESIDENCE NO. 941 N Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Sept 30-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

015

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm Sheets

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Elizabeth Sheets (Address) 2961 Chesterfield Ave.

15 Filed FEB 14 1923 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1923, to Feb 13, 1923, that I last saw him alive on Feb 13, 1923, and that death occurred, on the date stated above, at 4.40 p.m.

The CAUSE OF DEATH* was as follows:

Senile gangrene of left foot

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary): Toxemia - Coma.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 12/23

Was there an autopsy? No

What test confirmed diagnosis? Symp + Phy Signs

(Signed) D. J Pessagno, M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Feb 15 1923

20 UNDERTAKER: Fred A Frames & Son — ADDRESS: 703 Hanover

Sesel Tuchman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72464
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 D72464
Registered No. C.....

City of BALTIMORE: (No. 1736 N. Appleton St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Sesel Tuchman

(Residence in Baltimore: No. 1736 N. Appleton St. 2 yrs., 6 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male
4-COLOR OR RACE: white
5-Single, Married, Widowed, or Divorced, (Write the word.): married

6-DATE OF BIRTH: about (Month) (Day) 1855 (Year)

7-AGE: 68 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Dresser
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Austria

PARENTS:
10-NAME OF FATHER,
11-BIRTHPLACE OF FATHER, (State or Country),
12-MAIDEN NAME OF MOTHER,
13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Michael Goldstein
(Address) 1736 Appleton St.

15-
Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 13, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation Heart

(Duration) yrs. mos. ds.

(Signed) J. J. Kennedy M. D.
(Coroner.)

Feb. 14, 1923 (Address) 28 S. Eutaw Pl.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Lebanon Cem. DATE OF BURIAL, Feb. 17 1923

20-UNDERTAKER, Jack Lewis ADDRESS 1439 E. Pres

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72465

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72465

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2222 Essex (ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wojciech Helinski

(a) RESIDENCE. NO. 2222 Essex ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs ... mos. ... ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Helinski

6 DATE OF BIRTH (month, day, and year) Jany ? 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)..... Poland
(State or country)

PARENTS

10 NAME OF FATHER John Helinski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Frances Helinska.
(Address) 2222 Essex St.

15 FEB 14 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 20 1923, to Feby 12 1923, that I last saw him alive on Feby 11 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ... yrs. ... mos. 23 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb N Athey, M. D.

Feby 12 1923 Address) 1008 Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus, Cem,	Feby 15. 1923
20 UNDERTAKER	ADDRESS
M. F. Sadowski.	705 S. Ann St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Gilmor

Spec.—1-10-21—M&T—1500 Bks.

D72466

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

D72466

CERTIFICATE OF DEATH.

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Annie L. Gilmor

(a) RESIDENCE NO. 2719 St. Paul ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 17, 1847

7 AGE — Years: 75 — Months: 11 — Days: 26 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Baltimore City Schools

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robert Gilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Letitia Mord

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Summerfield Medairy

(Address) 2719 St. Paul St.

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1923, to Feb 12, 1923,

that I last saw her alive on Feb 12, 1923,

and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical - Autopsy

(Signed) James A. Wellson M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount — DATE OF BURIAL: July 14 1923

20 UNDERTAKER: John Ottenhall — ADDRESS: Bon Air Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D72467

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72467

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 Bayle ST., 24 WARD)

2-FULL NAME Hannah C Anderson

(a) RESIDENCE NO. 1510 Bayle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Anderson

6 DATE OF BIRTH (month, day, and year): Autumn

7 AGE: Years 64; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Andy Hoff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs C. Anderson

(Address) 1510 Bayle St.

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to Feb 12 1923

that I last saw h alive on Feb 12, 1923

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell M. D.

Feb 14, 1923 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Cedar Hill — DATE OF BURIAL: July 15 1923

20 UNDERTAKER: Robt Johnson — ADDRESS: 1422 N. Gay

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72468

CERTIFICATE OF DEATH.

31

D72468

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2608 Hillside Ave 8 WARD)

2-FULL NAME Catherine A Sellman

(a) RESIDENCE NO. 2608 Hillside Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): April 5 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John J Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Cash

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: George E Sellman

(Address): 2608 Hillside ave

15 Filed FEB 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1923, to Feb 13, 1923,

that I last saw h alive on Feb 12, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical signs

(Signed) [illegible], M. D.

Feb 13 1923 (Address) 1201 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Feb 16, 1923

20 UNDERTAKER: Robt J Turner Jr — ADDRESS 1442 N Broadway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72469

CERTIFICATE OF DEATH.

159-002 D72469

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 E. Hamburg ST. 13 WARD)

2-FULL NAME John Hartlove

(a) RESIDENCE NO. 20 E. Hamburg ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

NOTE B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 13. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Charles W. Hartlove

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Irene Wroten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Mrs. Chas. Hartlove
(Address) 20 E. Hamburg St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

FEB 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1923, to Feb 13, 1923, that I last saw h[illegible] alive on Feb 13, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Hospital

(Signed) [illegible], M. D.

2-14 1923 (Address) 1[illegible] Randall Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Feb. 14 1923

20 UNDERTAKER Margaret J. Flynn — ADDRESS 1422 Light St.

Spec.—1-10-21 M&T 1500 Bks.

D72470

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72470

CERTIFICATE OF DEATH.

31

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Neuholczak (Nukolczak) (this is carrect name)

(a) RESIDENCE NO. 504 Register st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tini Neuholczak

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Theo. Neuholczak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records

(Address) U. T. H.

15 FEB 4 1923 19 Robert F. [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1923, to Feb. 12, 1923,

that I last saw him alive on Feb. 12, 1923,

and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Daugherty M. D.

2-13-1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Feb 16 1923
20 UNDERTAKER	ADDRESS
John Madeber	1803 Bank St

Spec.—1-10-21—M&T—1500 Bks.

D72471

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72471

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 Franklin Terrace ST., 9 WARD)

2-FULL NAME Ann Bowen Edwards.

(a) RESIDENCE NO. 500 Franklin Terrace ST., 9 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24th 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	7 8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Francis A. Edwards.

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Blanche B. Bowen

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Blanche B. Edwards.
(Address) 500 Franklin Terrace

15 Filed Feb 14 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby. 9 1923. to Feby. 14 1923.

that I last saw her alive on Feby. 13 1923

and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual in such cases

(Signed) Wm. J. Gillespie, M. D.

, 19 (Address) 415 Cedar Croft Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 2/16 1923

20 UNDERTAKER Wm. Cook

ADDRESS 502 E. Madison

MARGIN RESERVED FOR BINDING

(1) B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72472

CERTIFICATE OF DEATH.

31

D72472

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 N. Fulton ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Smith

(a) RESIDENCE NO. 301 Fulton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE: Years 37; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) driving Coal

(c) Name of employer Wagon. Wm. Brown

9 BIRTHPLACE (city or town) (State or country) Hanover Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed Feb 14, 1923 Robert F. Carlisle, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11/1923

17 I HEREBY CERTIFY, That I attended deceased from 2/10/, 1923, to 2/11/, 1923,

that I last saw him alive on 2/10/, 1923,

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory Circumstances

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) P. L. Jackson, M. D.

2/13, 1923 Address) 767 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER: Commissioner Health, per. Wm. S. Norman

ADDRESS 19

FEB 14 1923

FEB 14 1923

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72473 D72473

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Providence Hospital

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.) No. 413-415 W Biddle St. 17 WARD)

2-FULL NAME Samuel Spencer Jennings

(a) RESIDENCE. No. 1203 Ethridge St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6. 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self. Baltimore

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER James W Jennings

11 BIRTHPLACE OF FATHER (city or town) (State or country) West River Maryland

12 MAIDEN NAME OF MOTHER Marguite E Morse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Charles C. Jennings
(Address) 1628 Druid Hill Ave

15 FEB 14 1923 . 19 ROBERT F. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febr 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Febr 9 . 1923 to Febr 12 . 1923 that I last saw h— alive on Febr 12 . 1923, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) None definite. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 514 Druid Hill

Did an operation precede death? No Date of

Was there an autopsy? No Physical

What test confirmed diagnosis?

(Signed) Wm. H. Wright, M. D.

Feb 12 . 1923 (Address) 1209 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Feb 15 1923

20 UNDERTAKER: Jno. M. Johnson

ADDRESS: 234 Ethridge St.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *HouseKeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal Condition

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72474

D72474

CERTIFICATE OF DEATH.

117

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 75 WARD)

2-FULL NAME Thos Jankiewicz

(a) RESIDENCE NO. 23 Third St ST.; ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Jankiewicz

6 DATE OF BIRTH (month, day, and year): Sept 26 1886

7 AGE: Years 36 Months 4 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Thos. Jankiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Cathemis ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Mary Jankiewicz Wagners Point

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

FEB 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 13 1923

17 I HEREBY CERTIFY That I attended deceased from Feb 10, 1923, to Feb 13, 1923,

that I last saw ~~him~~ alive on Feb 13, 1923

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Rupture Gangrenous Appendix.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Peritonitis, Toxemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 2/10/23 Appendectomy

Was there an autopsy? .....

What test confirmed diagnosis? Operation.

(Signed) J. T. Savage M. D.

2/13 1923 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross

DATE OF BURIAL: 2/15 1923

20 UNDERTAKER: Wm Faulkowski

ADDRESS: 1118 Eastern

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

FEB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72475

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72475

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mercy Hospital ST., 4 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Dixon

(a) RESIDENCE NO. 708 W Mulberry ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David A. Dixon

6 DATE OF BIRTH (month, day, and year): 1843

7 AGE — Years: 71. Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Neill Caldwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Brogan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Son 708 W Mulberry St.

FEB 14 1923

Robert F. Harrison, 19

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13 1923 that I last saw h She alive on Feb 13 1923 and that death occurred, on the date stated above, at 7 1/4 a.m.

The CAUSE OF DEATH* was as follows:
Cerebral apoplexy
6 ds.

CONTRIBUTORY (Secondary) Pulmonary edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Sympt. & Signs

(Signed) C. J. Greenwood M. D.
, 19 (Address) 1 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL 2/15 19 23

20 UNDERTAKER: H. A. Mahoney ADDRESS 1315 Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

D72476

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72476

CERTIFICATE OF DEATH.

7H-101

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 11 N. Gorman Ave. ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F. Zeller

(a) RESIDENCE NO. 11 N. Gorman Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Zeller

6 DATE OF BIRTH (month, day, and year) Nov. 2nd 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cutter & presser

(b) General nature of industry, business, or establishment in which employed (or employer) Schloss Bros.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Mary Zeller (Address) 11 N. Gorman Ave.

15 Filed FEB 14 1923, 19 Robert P. Carlin, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12th 1923

17 I HEREBY CERTIFY, That I attended deceased from January 30, 1923, to February 12, 1923, that I last saw him alive on " " 1923, and that death occurred, on the date stated above, at 8.15P. m.

The CAUSE OF DEATH* was as follows:

Goleris sclerosus

Chronic Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Edw. L. Coolahan, M. D.

2/13 1923 (Address) 24 E. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Feb. 15 1923

20 UNDERTAKER Joseph Block ADDRESS 1003 W. Balto. St.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72477 90 D72477

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 S. Poppleton St. ST., 14 WARD)

2-FULL NAME John H. Kratzenstein

(a) RESIDENCE NO. 36 S. Poppleton St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kratzenstein

6 DATE OF BIRTH (month, day, and year) Nov. 2" 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Kratzenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary Kratzenstein
(Address) 36 S. Poppleton St.

15 Filed ..... 19 .....
FEB 14 1923 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13" 19 23

17 I HEREBY CERTIFY, That I attended deceased from Jan 12 1923 to Feb 13 1923.

that I last saw h[illegible] alive on Feb 13 1923.

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

2/14 23 (Address) 835 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Feb. 16 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bolton St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72478

D72478

66

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

2-FULL NAME Richard A Pardoe

(a) RESIDENCE NO. E. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Rigger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER James H. Pardoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Sarah Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant: Albert W. Smith

(Address) 849 S. Paca St.

15 Filed , 19 Registrar

ROBERT F. [illegible]

Burial Permit Clerk

FEB 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14th 19 23

17

I HEREBY CERTIFY, That I attended deceased from Jan 30 , 1923 , to Feb 14 , 1923 ,

that I last saw h[illegible] alive on Feb 13 , 1923 ,

and that death occurred, on the date stated above, at 4:40 m.

The CAUSE OF DEATH* was as follows:

Chronic alcoholism

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wm. Sayres M. D.

2/14 19 23 (Address) 1 Mass. Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery | DATE OF BURIAL: Feb 17 1923

20 UNDERTAKER: Joseph B. Cairs | ADDRESS: 1003 N. Gay St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NOTE B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D72479

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122-002 D72479

1-PLACE OF DEATH Copy from

CITY OF BALTIMORE: (No.) Mt Washington ST., 21 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Dailey

(a) RESIDENCE NO. Poplar Ave. Mt Washington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 1849

7 AGE — Years: 73 — Months: 6 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country)

PARENTS

10 NAME OF FATHER Jesse Daily

11 BIRTHPLACE OF FATHER (city or town) Balto Co. (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Mrs. Palmer Relands Md

Filed FEB 14 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1923, to Feb 12, 1923, that I last saw h e alive on Feb 11, 1923, and that death occurred, on the date stated above, at 11 1 m.

The CAUSE OF DEATH* was as follows:

Sclerosis of Liver - Senile degeneration

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Jaundice - Vomiting —

(Signed) C. H. Beetem M. D.

, 19 (Address) Mt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Relands — DATE OF BURIAL: Feb 15, 1923

20 UNDERTAKER: E. [illegible] Duffy — ADDRESS: 1258 E. Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D72480

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72480

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 Hanover ST., 27 WARD)

2-FULL NAME Cristoforo C. Lamartina

(a) RESIDENCE NO. 629 Hanover ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 27 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 16. 1921

7 AGE 1 Years 10 Months 27 Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. City (State or country)

PARENTS

10 NAME OF FATHER Rosario Lamartina

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Concettina Alma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rosario Lamartina

(Address) 629 Hanover st

15 Robert P. Harrison, Registrar

FEB 14 1923 .....19.....

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-12- 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 , 1923 , to Feb 12 , 19 ,

that I last saw him alive on Feb 12 , 19 23

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chs. Testa M. D.

, 19 (Address) 210 Pearl st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL 2/15/23

20 UNDERTAKER George J. Ruth — ADDRESS 1238 Harford Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RE[CORD].

FEB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 14 1923

D72481 HEALTH DEPARTMENT—CITY OF BALTIMORE D72481

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hosp St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Bailey

(Residence in Baltimore: No. 3803 Conduit Ave St.; yrs. 1 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Aug (Month) 17 (Day) 1923 (Year)

7-AGE. 19 yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mill hand
(b) General nature of industry, business, or establishment in which employed (or employer): Cotton duck

9-BIRTHPLACE, (State or Country). Prince William Co Va

PARENTS.

10-NAME OF FATHER. John H. Bailey

11-BIRTHPLACE OF FATHER, (State or Country). Prince Wm Co Va

12-MAIDEN NAME OF MOTHER. Alice O'Arrington

13-BIRTHPLACE OF MOTHER, (State or Country). Prince Wm Co Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. A. Hammond

(Address) 3803 Conduit Ave

15- Robert P. Harrison, 192.... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby (Month) 13 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(Duration) Probably yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Abortion self induced

(Duration) yrs. mos. ds.

(Signed) J. H. Oden M. D. (Coroner.)

2-14 1923 (Address) 4 E. Eager

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Occoquan Va

19-PLACE OF BURIAL OR REMOVAL Prince William Co Occoquan Va DATE OF BURIAL, Feb 14 1923

20-UNDERTAKER, Walter P. McTamney ADDRESS 802 Hollins Ave

Spec.—1-10-21—M&T—1500 Bks.

Kimball

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72482

CERTIFICATE OF DEATH.

31 D72482

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridellia Kimball

(a) RESIDENCE NO. 125 N. Bradford ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Sing'l

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edw S. Kimball

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Esther Otho

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs. Kimball (Address) 125 N. Bradford

15 Filed ....., 19.... Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-14 1923

17 I HEREBY CERTIFY, That I attended deceased from January 20, 1923, to February 14, 1923, that I last saw h.. alive on February 14, 1923, and that death occurred, on the date stated above, at 6:15 a m.

The CAUSE OF DEATH* was as follows:

Brain Ulcers

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Miliary Tbc., Bronchopneumonia, Pulmonary Ulcers

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) Moses Gellman, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL 2/16 1923

20 UNDERTAKER J. F. McCarthy ADDRESS 130 E. Front

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 14 1923

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

1923
170

D72483

HEALTH DEPARTMENT—CITY OF BALTIMORE

114 D72483 853

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1632 Bruce St (St.) 15 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wright Powell

(a) RESIDENCE NO. 1632 Bruce ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Grenville Autrey

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant Ella Thomas

(Address) 1436 Mt Prospect Ave

15 FEB 15 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14 1923

17 I HEREBY CERTIFY, That I attended deceased from 1/24, 1923, to 2/14, 1923,

that I last saw h[illegible] alive on 2/14, 1923

and that death occurred, on the date stated above, at 12 10 P m.

The CAUSE OF DEATH* was as follows:

Chr. Gastro-enteritis -

& senility -

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) about 1 mo

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bruce Cuthy, M. D.

2/14 1923 (Address) 2137 D St. S.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Feb 16th 1923

20 UNDERTAKER: Hamme & Wright — ADDRESS: 624 Cary

Spec.—1-10-21—M&T—1500 Bks.

(Mike)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72484

CERTIFICATE OF DEATH.

113 D72484

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231½ S Madeira ST., 1 WARD)

2-FULL NAME Joseph Mik

(a) RESIDENCE NO. 231½ S Madeira ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 8 1922

7 AGE — Years: — Months: 2 Days: 5 If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Andrew Mik

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Pienta

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Andrew Mik

(Address) 231½ S Madeira

15 FEB 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 13 9-30 am. 1923 to Feby 13 1923,

that I last saw him alive on Feby 13 1923

and that death occurred, on the date stated above, at 430 P m.

The CAUSE OF DEATH* was as follows:

Diarrhoea

Convulsions

(duration) yrs. ..... mos 10 hours ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Cedar Whitney, M. D.

Feby 14 1923 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus — DATE OF BURIAL: Feb 15 1923

20 UNDERTAKER: John M Weber — ADDRESS: 1803 Bank St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72485

CERTIFICATE OF DEATH.

D72485

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 54 Raspe Ave ST., 26 WARD)

2-FULL NAME Wm Vernon Schnibbe

(a) RESIDENCE NO. 54 Raspe Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Wm A. Schnibbe

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Elizabeth A. Weiss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Wm D. Schnibbe
(Address) 54 Raspe Ave

15 FEB 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923, to Feb 13, 1923, that I last saw him alive on Feb 13, 1923, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Measles.

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert H. Slater, M. D.

. 19 (Address) 703 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem.

DATE OF BURIAL 2/15 1923

20 UNDERTAKER Philip Henry

ADDRESS 3016 Ellamus

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

161602
D72486

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D72486

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 5

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florine Simmons

(a) RESIDENCE No 1417 E. Fairmont Ave City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17, 1922

7 AGE — Years: — Months: 6 — Days: 26 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER John Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina

12 MAIDEN NAME OF MOTHER Sadie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Jersey

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 FEB 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1923, to Feb. 13, 1923, that I last saw her alive on Feb. 13, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia and Empyema

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes Thoracentesis resulted in pus showing pneumococcus on culture

What test confirmed diagnosis?

(Signed) William H. F. Wartheu, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Feb 15 1923

20 UNDERTAKER: R C Gross — ADDRESS: 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D72487

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D72487

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp S. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Joshua Robinson

(Residence in Baltimore: No. 1115 N. Port St.; yrs. 6 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Widower

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1861 (Year)

7-AGE.	If LESS than 1 day,
..... yrs. 18 mos. ..... ds.	..... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS

10-NAME OF FATHER. Joshua Robinson

11-BIRTHPLACE OF FATHER, (State or Country). N. Carolina

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. E. Groot

(Address) 1405 McElderry

15- Filed FEB 15 1923, 192... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb (Month) 14 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer Bronchus

Incurable

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Follin M. D. (Coroner.)

2 15 1923 (Address) 1306 York Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (I) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel	Feb 15 1923
20-UNDERTAKER	ADDRESS
R. E. Groot	1405 McElderry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RE

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72488

CERTIFICATE OF DEATH.

D72488

101-00

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2901 St. Paul ST. 17. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Montgomery Jr.

(a) RESIDENCE. No. 2901 St. Paul St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah M. Montgomery

6 DATE OF BIRTH (month, day, and year): Feby 24 1846

7 AGE: Years 77 Months — Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Promoter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Conn.

PARENTS

10 NAME OF FATHER: Wm. Montgomery

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass.

12 MAIDEN NAME OF MOTHER: Susan Halliday

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass

14 Informant: Sarah M. Montgomery
(Address): 2901 St. Paul St.

15 Filed FEB 15 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 11 1923, to Feby 14 1923, that I last saw him alive on Feby 13 1923, and that death occurred, on the date stated above, at 5.30 Am.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia —

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Wm W. Lamar — M. D.

Feb 14 1923 (Address) 134 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feby 16 1923

20 UNDERTAKER	ADDRESS
Wm O. Mitchell	1201 W. Fayette

Spec. 6-9-19—H. P. Co.—1000 Blks.

D72489 HEALTH DEPARTMENT—CITY OF BALTIMORE D72489

CERTIFICATE OF DEATH.

90v

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Frederick Road (North) (Bend) ST.; 8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Charles M. Stockett

(a) RESIDENCE. (No.) Frederick Road (North) (Bend) ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maria E. Stockett

6 DATE OF BIRTH (month, day, and year): Mar 29, 1833

7 AGE — Years: 89 — Months: 10 — Days: 24 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): A. A. Co. Md.

PARENTS

10 NAME OF FATHER: Jos. N. Stockett

11 BIRTHPLACE OF FATHER (city or town) (State or country): A A Co Md

12 MAIDEN NAME OF MOTHER: Sophia Mathews

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A. A. Co Md

14 Informant: Jos N. Stockett

(Address): 1430 Linden Ave

15 Filed FEB 15 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1922, to Feb 13, 1923, that I last saw h[illegible] alive on Feb 10, 1923, and that death occurred, on the date stated above, at 8. P. - m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Dr. H. Pearce, M. D.

, 1923 (Address) 2105 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feby 15 1923

20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W. Fay

D72490

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72490
REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2238 Rayner ST. 16 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1S.)

2-FULL NAME Mary E. Tucker

(Residence in Baltimore: No. 2238 Rayner St.; yrs. 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, July 6 (Month) (Day), 1852 (Year)

7-AGE, 70 yrs. 7 mos. 7 ds.
If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Talbott Co Md.

PARENTS.

10-NAME OF FATHER, John W. Harper

11-BIRTHPLACE OF FATHER (State or Country), Talbott Co Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. J. Fred Hawkins
(Address) 1 E. Randall

15-
Filed FEB 15 1923 191.. ROBERT R. KRAUTER,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 12, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) senile tremor,

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner)

Feb. 15, 1923 (Address) 1802 Eutaw pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cem	2/15, 1923
20-UNDERTAKER	ADDRESS
J. Fred McCully	130 E. Fort.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72491

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D72491

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 Rock ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Fields

(a) RESIDENCE NO. 206 Rock ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (~~HUSBAND of~~) (or) WIFE of: John Fields

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 48 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General House work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: John Fields

(Address): ROBERT R. KRAUTER

15 Filed Feb 15 1923 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/11/1923

17 I HEREBY CERTIFY, That I attended deceased from 11/21, 1922, to 2/11, 1923, that I last saw her alive on 2/10/, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Valvulitis

(duration) Indeterminate yrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?: —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. J. Howells M. D.

2/15, 1923 (Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: Feb 15 1923.

20 UNDERTAKER: Samuel T Hemsley ADDRESS: 578 W Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72492

CERTIFICATE OF DEATH.

31 D72492

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5 Penn ST., 4 WARD)

2-FULL NAME Joseph J. Satterwhite

(a) RESIDENCE NO. 5 Penn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Satterwhite

6 DATE OF BIRTH (month, day, and year): Sept 10 1889

7 AGE: Years 33 Months 5 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter 086

(b) General nature of industry, business, or establishment in which employed (or employer): Tailor Shop.

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jerome Satterwhite

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Satterwhite

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Minnie Satterwhite 5 Penn St

15 Filed FEB 15 1923, 19 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-13- 1923

17 I HEREBY CERTIFY, That I attended deceased from 11-15- 1923 to 2-13- 1923, that I last saw him alive on 2-12- 1923 and that death occurred, on the date stated above, at 3,30 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(duration) Cant Know. yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy.

(duration) yrs. 4 mos. 13 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jno. H. Carmichael, M. D.

2-14- 1923 (Address) 611-N- Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery — DATE OF BURIAL 19

20 UNDERTAKER: Emmett T. Hegerley ADDRESS 578 N Bridle

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72493

CERTIFICATE OF DEATH.

90

D72493

REGISTERED NO.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Hawkins

(a) RESIDENCE NO. 1313 Division St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	64	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) Virginia

PARENTS

10 NAME OF FATHER William Buddie

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bell Floyd

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Virginia

14 Informant Municipal Hospital Records.

(Address)

15 Filed FEB 15 1923, 19 ... ROBERT E. KRAUTZ ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from February 7, 1923, to February 13, 1923, that I last saw her alive on February 13, 1923, and that death occurred, on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) J. A. McKay, M. D.

2-13-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Pleasant Cem — DATE OF BURIAL July 16 1923

20 UNDERTAKER Samuel Hawley — ADDRESS 918 N Bridle

Spec.—1-10-21—M&T—1500 Bks.

D72494

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72494

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Univ. Hospital

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

2-FULL NAME James L. Smith.

(a) RESIDENCE NO. Pimplurey Station ST. Md WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Blk.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Smith

6 DATE OF BIRTH (month, day, and year) June 25 1870

7 AGE: Years 52; Months; Days; If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): farming

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kentucky.

PARENTS

10 NAME OF FATHER Walter Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Elizabeth McGraw

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Univ. Hosp. Records
(Address)

15 Filed FEB 15 1923 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12. 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/10 .1923. to 2/12 .1923.

that I last saw him alive on 2/12 .1923,

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis with decompensation

generalized anasarca. C.P.C. Liver

(duration) yrs. mos 45 ds.

CONTRIBUTORY (Secondary) Chr Emphysema, and Bronchitis (duration) yrs. mos. 45 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [redacted] M. D.

2-13-1923 (Address) Univ Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 2-16-15 1923

20 UNDERTAKER: Samuel W. Cleaver & Son — ADDRESS: 1408 Maker

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72495 D72495

CERTIFICATE OF DEATH.

XV 11-06

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 N. Mount ST. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Pea

(a) RESIDENCE. No. 318 N Mount ST., WARD. Virginia

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cassor Pea.

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 73 — Months 10? — Days ? — If LESS than 1 day, hrs. or min.

Dispute among family?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Essex Co Va

PARENTS

10 NAME OF FATHER: Edmund Yates

11 BIRTHPLACE OF FATHER (city or town) (State or country): Essex Co Va

12 MAIDEN NAME OF MOTHER: Martha Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Essex Co Va.

14 Informant: Thomas Washington

(Address) 1352 N. Caroline St

15 Filed FEB 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1923 to Feb 12, 1923, that I last saw h— alive on Feb 9, 1923, and that death occurred, on the date stated above, at 1.35 P.M.

The CAUSE OF DEATH* was as follows:

"Influenza"

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wilbur F. Magat, M. D.

(Address) 1209 Preston and

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bowlys Mill Essex Co Va

DATE OF BURIAL: Feb 16 1923

20 UNDERTAKER: Wm. H. Chase & Son

ADDRESS: 1400 Madison St

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72496

CERTIFICATE OF DEATH.

129 D72496

REGISTERED NO.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1 Hospital Loop St.; 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Kinsley

(a) RESIDENCE. No. 1 Hospital Loop St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — — 1858

7 AGE: Years 65; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Sisters of Charity St. Vincent's Female Orphan Asylum Paca & Lexington Sts.

15 Filed FEB 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14 19 23

17 I HEREBY CERTIFY, That I attended deceased from February 9 19 23 to Feb 14 19 23.

that I last saw h alive on Feb 14 19 23.

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Myocard. Insufficiency.

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Schumich M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: 2/16 19 23

20 UNDERTAKER: J. Wakefield

ADDRESS: 1318 Eutaw

Spec.—1-10-21—M&T—1500 Blks.

D72497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 124 D72497

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N. Curley ST., WARD)

2-FULL NAME Elizabeth Reisig

(a) RESIDENCE NO. 412 N. Curley ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Christian Reisig

6 DATE OF BIRTH (month, day, and year) July 7, 1831

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	91	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Andrew Freeburger

(Address) 412 N. Curley

15 FEB 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 21, 1922, to July 13, 1923,

that I last saw h.e alive on July 11, 1923,

and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Old Age —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W. White M. D.

2/14, 1923 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthews — DATE OF BURIAL Feb 16 1923

20 UNDERTAKER Junkler & Junkler — ADDRESS 1799 Eager

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72498

CERTIFICATE OF DEATH.

44 D72498

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4136 Norfolk Ave St.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Wilhelm Viehmeyer

(a) RESIDENCE. No. 4136 Norfolk Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a ~~If married, widowed, or Divorced~~ (HUSBAND) of Elmira H Viehmeyer

6 DATE OF BIRTH (month, day, and year) Sept 17-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61y	4 mo	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Fire Department 03rd

(c) Name of employer Baltimore City 0

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER ? Viehmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Henrietz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Alma Schumann
(Address) 4136 Norfolk Ave

15 Filed FEB 15 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 13 1923

17 I HEREBY CERTIFY, That I attended deceased from February 8, 1923, to February 14, 1923, that I last saw h[illegible] alive on February 12, 1923, and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Influenza.

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Carcinoma of esophagus

(duration) — yrs. 14 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) Chester Piland, M. D.

2-14, 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	2/16 1923

20 UNDERTAKER Robt L Little ADDRESS 2530 Edmondson Ave

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72499

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72499

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1335 Myrtle Ave St. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Harrison

(Residence in Baltimore: No. 1335 Myrtle Ave. St.; 74 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	widower

6-DATE OF BIRTH, about, 1848
(Month) (Day) (Year)

7-AGE, 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer): Produce

9-BIRTHPLACE (State or Country), Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Morris Atkinson

(Address) 516 Pine St.

15-FEB 15 1923

Filed ..... 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 12, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Feb. 13, 1923 (Address) 2802 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, National Cem. DATE OF BURIAL, Feb 15 1923

20-UNDERTAKER George A. Fuhrman ADDRESS 513 Fairmount

Spec.—1-10-21—M&T—1500 Bks.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

161421 Paid

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72500

D72500

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 9 WARD)

JOHNS HOPKINS HOSPITAL

2-FULL NAME Harry Moses

(a) RESIDENCE NO. 2 W. East St. Spanish Pt WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Adolph Moses

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Helen ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Brady

(Address) JOHNS HOPKINS HOSPITAL

15 FILED FEB 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1923

I HEREBY CERTIFY, That I attended deceased from Feb 3, 1923, to Feb 10, 1923, that I last saw h[illegible]alive on Feb 10, 1923, and that death occurred, on the date stated above, at 3.05 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Primary

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Mead, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL FEB 14 1923

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72501

CERTIFICATE OF DEATH.

38

D72501

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Bay View Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo C. Adams

(a) RESIDENCE NO. 116 S Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN, RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Augustus Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 FEB 15 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 19 23

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1923, to Feb 12, 1923, that I last saw h alive on Feb 12, 1923, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Mania

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Phthisis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Results of

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Feb 16 1923

20 UNDERTAKER Wendell & Hopper ADDRESS 1005 Park Ave

Spec.—1-10-21—M&T—1500 Blks.

D72502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72502

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2710 E. Monument St., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence L. Kaufman

(a) RESIDENCE NO. 2710 E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb. 12-1923

7 AGE: Years — Months — Days 3 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Bernard Kaufman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Rosa Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Bernard Kaufman

(Address): 2710 E. Monument St

15 Filed FEB 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1923, to Oct 14, 1923,

that I last saw her alive on Oct 14, 1923,

and that death occurred, on the date stated above, at 5:15 a m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan Schmitt, M. D.

Feb 15, 1923 (Address) 701 N Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Feb 16 1923

20 UNDERTAKER: Geo M. Frank & Son

ADDRESS: 811 W Lexington

...ECORD. Every item of infor-
...Y. PHYSICIANS should state
...d. Exact statement of OCCUPA-
...ertificates.
...CAU...
...TION is very im...

Spec.—1-10-21 M&T 1500 Bks.

D72503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D72503

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Diggs

(a) RESIDENCE NO. Bay View Hospital. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	86	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Municipal Hospital Records.
(Address)

15 Filed FEB 15 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1923

17

I HEREBY CERTIFY, That I attended deceased from January 23 1923 to February 14 1923.

that I last saw h alive on February 13 1923.

and that death occurred, on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKay, M. D.

2-14 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilkens Ave. DATE OF BURIAL Feby 16 '23

20 UNDERTAKER G. T. Scudder & Son ADDRESS Northern

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72504

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 E-25" St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Gardner

(Residence in Baltimore: No. 400 E-25 St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

6-DATE OF BIRTH. Unknown ..... (Month) ..... (Day) ..... (Year)

7-AGE. 60 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucie Gardner

(Address) 400 E. 25 St

15- Filed FEB 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 12 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest Autopsy or Inquiry thereon and from the evidence obtained I said Inquest, Autopsy, or Inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. Morrissey M.D. (Coroner)

1923 (Address) 3622 Roland Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery DATE OF BURIAL, Feb 15, 1923

20-UNDERTAKER, Wm Hirshfield & Sons ADDRESS North & Pa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72505 — 129 — D72505

CERTIFICATE OF DEATH.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Protestant Inf ST. 15 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Cahill

(a) RESIDENCE NO. 2132 Mt Holly ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Mrs J J (Mary) Cahill

6 DATE OF BIRTH (month, day, and year) Jan 4-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Cahill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Naughton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary Cahill
(Address) 2132 Mt Holly St

15 Filed DEC 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14, 19 23

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 19 23, to Feb 14, 19 23,
that I last saw him alive on Feb 14, 19 23,
and that death occurred, on the date stated above, at 6 15 A. m.

The CAUSE OF DEATH* was as follows:

chronic nephritis & uremia

(duration) 5 (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? blood chemistry

(Signed) P.B. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cemetery — DATE OF BURIAL 12/17 1923

20 UNDERTAKER Chas P Evans & Son — ADDRESS 1180 Mont Royal Ave

D72506

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72506

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St. N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Bryant Sturley

(Residence in Baltimore: No. 3529 Clairmont ave St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, ~~Widowed~~ or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, July 15 1921
(Month) (Day) (Year)

7-AGE. 1 yrs. 11 mos. 30 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Edgar Sturley

11-BIRTHPLACE OF FATHER, (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Grace Newbauer

13-BIRTHPLACE OF MOTHER, (State or Country), N.Y. city

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace Sturley

(Address) 3529 Clairmont

15-

Filed ..... 192 RUDLA... Burial Permit Clerk, Registrar.

FEB 15 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 14 1923?
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prostate - Longitudinal Sinus Thrombosis or Brain Abscess

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Infection of prostate from injury under eye (Duration) 2 yrs. 7 mos. 30 ds.

(Signed) Jos. E. Cotter M. D.
(Coroner.)

2-15 1923 (Address) 506 E. North ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Schwartz Cem DATE OF BURIAL. Feby 17 1923

20-UNDERTAKER. John Reeside ADDRESS. 2008 Allendale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72507

CERTIFICATE OF DEATH.

24-001 D72507

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3817 Fernwood Ave St.) (No. 76 WARD)

2-FULL NAME Sarah Catherine Goodwin

(a) RESIDENCE NO. 3817 Fernwood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. E. Goodwin

6 DATE OF BIRTH (month, day, and year): March 10-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Louis Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Martha Banes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto., Md.

14 Informant (Address): John H. Weil 3817 Fernwood ave

15 Filed FEB 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to Feb 14, 1923, that I last saw h[e] alive on Feb 13, 1923, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Haemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No Observation

What test confirmed diagnosis?

(Signed) Horace Fetlow M. D.

2/14 1923 Address 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery

DATE OF BURIAL: Feb. 17 1923

20 UNDERTAKER: Zirkler + Zirkler

ADDRESS: 1739 E. Eager

Spec.—1-10-21—M&T—1500 Bks.

D72508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 D72508

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE (No. ... St., 11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Price

(a) RESIDENCE NO. 907 N. Eutaw St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: John Price

6 DATE OF BIRTH (month, day, and year): 1851

7 AGE: Years 72. Months ... Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Connecticut

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital Balto Md.

15 FEB 15 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1922, to Feb. 13, 1923

that I last saw h[illegible] alive on Feb. 13, 1923

and that death occurred, on the date stated above, at 10:40 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Tumor)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Brain Tumor (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. A. Edmunds M. D.

2/14/1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	2/16/1923
20 UNDERTAKER	ADDRESS
Geo. A. Farley	[illegible] Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D72509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72509

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH Southern Hospital. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2520 Greenmount ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Barclay.

(Residence in Baltimore: No. 2426 Maryland Ave. If non-resident give usual residence.) (If LESS than 1 year, yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., (Month) (Day) 1869 (Year)

7-AGE, 54 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Milliner
(b) General nature of industry, business, or establishment in which employed (or employer) 886

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Don't Know

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. J. Barclay

(Address) 2426 Maryland Ave

15- Robert P. Garrison

Filed ....., 191.....

Burial Permit Clerk. Registrar.

FEB 15 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 14 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 24 1922, to Feb. 14 1923, that I saw h.r alive on Feb. 14 1923, and that death occurred, on the date stated above, at 7 30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma des. colon

..... (Duration) ..... yrs. 10 mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) ..... yrs. ..... mos. 1 ..... ds.

(Signed) Dudley P. Bowe M. D.

Feb. 14, 1923 (Address) 1904 N. Chas.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Valhalla Westchester Cem. DATE OF BURIAL, Feb. 15, 1923

20-UNDERTAKER Steen & Cooke ADDRESS 502 E. Monu

MARG... RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.

Spec.—1-10-21—M&T—1500 Bks.

D72510

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 ✓

D72510

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1572 Richland ST., 13 WARD)

2-FULL NAME Herman J. Mendler

(a) RESIDENCE No. 1572 Richland ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Wh	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 7/22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Paul Mendler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER May Grayking

13 BIRTHPLACE OF MOTHER (city or town) Balto Co Md.

14 Informant (Address) Mrs May Mendler 1572 Richland St

15 FEB 15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14th 1923

17 I HEREBY CERTIFY, That I attended deceased from July. 12 1923, to July. 14th 1923.

that I last saw b[illegible] alive on July. 14th 1923.

and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

Treated by mother, until Monday 2 P.M.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Weakness of Constitution

(duration) yrs. mos. one ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) E A Smith M. D.

7/14, 1923 (Address) 1605 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	July. 16 1923
20 UNDERTAKER	ADDRESS
William Lock	5026 E. North Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72511

CERTIFICATE OF DEATH.

74001 D72511

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Milton Ave. (ST.:) Lakeland (25th WARD)

2-FULL NAME Mrs. Ida Virginia Giles.

(a) RESIDENCE. (No.) Milton Ave. (ST.) Lakeland (25th WARD.)
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Giles

6 DATE OF BIRTH (month, day, and year): Feb 20, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): West Island Md.

PARENTS

10 NAME OF FATHER: Edward Kingsale

11 BIRTHPLACE OF FATHER (city or town) (State or country): West Island Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Island Md.

14 Informant: William Giles
(Address): Milton Ave. Lakeland Md.

15 Robert P. Harrison, Registrar
Burial Permit Clerk.

FEB 15 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 14. 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1922, to Feb 14, 1923, that I last saw her alive on Feb 14, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 3 mos. 20 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Thaurean Mackenzie M.D.

. 19 (Address) Lansdowne P.O. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Feb 17 1923
20 UNDERTAKER: E. Sehlman & Son	ADDRESS: 1034 Baltimore

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72512

CERTIFICATE OF DEATH.

D72512

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Univ Hospital ST., 4 WARD)

2-FULL NAME Mrs Maggie Arnold

(a) RESIDENCE NO. Mitchellville Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.... Farmerette

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edw Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

FEB 15 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1923, to Feb 13, 1923.

that I last saw her alive on Feb 13 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma left breast

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Jan 17

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy, history, operation

(Signed) [illegible] M. D.

2/14, 1923 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Collington Station Md

DATE OF BURIAL 2-16, 1923

20 UNDERTAKER E & B Hahn

ADDRESS 115 E Mead St.

Spec.—1-10-21—M&T—1500 Blks.

D72513

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D72513

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Roland Park

CITY OF BALTIMORE: (No.) 1 Sommerset Rd. ST., 27 WARD)

2-FULL NAME Regina Kirchhoff Walter

(a) RESIDENCE NO. 1 Sommerset Rd ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (~~write the word~~): Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Alfred Walter.

6 DATE OF BIRTH (month, day, and year): 1849-8-6

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): New Orleans La.

PARENTS

10 NAME OF FATHER: Fredk W. Kirchhoff

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Welham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Orleans La.

14 Informant: Alfred Walter.

(Address): Sommerset Road.

Filed FEB 15 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923, to Feb 14, 1923, that I last saw her alive on Feb 14, 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Mural Dr Obesity

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. D Atkinson, M. D.

Feb 15, 1923 (Address) 1010 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: 2-17 1923

20 UNDERTAKER: Henry W Truckin & Sons

ADDRESS: Mitchell & Orchard

MARGIN RESERVED FOR BINDING

FB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72514

CERTIFICATE OF DEATH.

D72514

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Severn Apt ST., [redacted] WARD)

2-FULL NAME Alonzo L. Thomsen

(a) RESIDENCE No. Severn Apt ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~
Male	White	Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) Sept 1st 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Manufctr.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John J. Thomsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emmalena Lilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm. H. J. Thomsen

(Address) 1928 Mt Royal Terr

15 Filed ....., 19 .....

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1923

17

I HEREBY CERTIFY, That I attended deceased from May 13, 1918, to Feb. 9, 1923.

that I last saw h[illegible] alive on Feb. 9, 1923,

and that death occurred, on the date stated above, at 11 30a m.

The CAUSE OF DEATH* was as follows:

Nephritis: Cardiac hypertrophy: Arteriosclerosis: Arterial hypertension.

(duration) about yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) Bedridden several years yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thos L Brown, M. D.

Feb 14, 1923 (Address) 17 W Bd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL 2-16 1923

20 UNDERTAKER Howard Kuhns Home Co — ADDRESS Guilford Orchard

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72515

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72515

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 N. Front ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wernsing

(a) RESIDENCE NO. 406 N. Front ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Strickhouser

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman - Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Continental Trust Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William Wernsing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER ------ Camper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Eugene Wernsing (Address) 406 N. Front St.

15 Filed FEB 15 1923 Robert P. Harrison, Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Apl. 7. 1922 to Feb. 13 1923.

that I last saw h[illegible]ive on Feb. 13 1923

and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Deabetes Mellitus

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. E. Rumbach M. D.

2/14 1923 (Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 2/16 1923

20 UNDERTAKER Henry W. Mears & Son 805 ADDRESS N. Calvert

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72516

CERTIFICATE OF DEATH.

129 D72516

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 316 S Exeter ST.: 3 WARD)

2-FULL NAME Teresa Mariello

(a) RESIDENCE. No. 316 S Exeter ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Mariello

6 DATE OF BIRTH (month, day, and year) March 20 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Theresa Adrasmo

(Address) 316 S Exeter

15 Filed ... 19... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923, to Feb 13, 1923, that I last saw h e alive on Feb 13, 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. [illegible] M. D.

Feb 15, 19 23 (Address) 414 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb 16 19
20 UNDERTAKER	ADDRESS
Windell Appel & Son	378 Lem

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 15 1923

Burial Permit Clerk.

D72517

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D72517

100-002V

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1815 Pulaski St. 15 WARD)

Registered No. C

(If death occured a hospital or institut give its NAME Instead street and number fill out No. 18.)

2 FULL NAME Sarah Jane Anderson

(Residence in Baltimore: No. 1815 Pulaski St.; 75 yrs. mos. d

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Feb 14, 1842 (Month) (Day) (Year)

7 AGE: 80 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9 BIRTHPLACE (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Mumford

11 BIRTHPLACE OF FATHER (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (State or country): Balto Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth H Anderson
(Address) 1815 N Pulaski

15 Robert P. Harrison, M.D., 191
Burial Permit Clerk REGISTRAR

FEB 15 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb 15th, 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased fr Feb 13th, 191 23, to Feb 15th 19 23, that I saw her alive on Feb 14, 191 23, and that death occurred, on the date stated above, at 2.25

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. 3 mos.

Contributory (SECONDARY) Cold

(Duration) yrs. mos.

(Signed) C. H. Laboratz M.

Feb 15, 1923 (Address) 2413 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAU state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIEN or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: 2/17, 191

20 UNDERTAKER: W. D. Cook

ADDRESS: 702 N. Fr

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Clayton Hunter)

Spec.—1-10-21—M&T—1500 Bks.

D72518 HEALTH DEPARTMENT—CITY OF BALTIMORE D72518.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 4 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifton Hunter

(a) RESIDENCE NO. Fairchild Rd ST., WARD Gaithers Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Hunter

6 DATE OF BIRTH (month, day, and year) Nov 16 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37.	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engine Maintainer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Charles Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary Minnick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant E. O. Pritchett

(Address) Sykesville Md

15 Filed . 19 Robert F. Harrison Burial Permit Clerk. Registrar

5 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 19 23

17 I HEREBY CERTIFY That I attended deceased from Dec 30 . 19 23 . to Feb. 15 . 19 23

that I last saw h in alive on Feb 15 . 19 23

and that death occurred, on the date stated above, at 4" P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder

(duration) yrs. 2 mos. ds

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 3 ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-3-23 Appendectomy

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy & Path. findings

(Signed) E. O. Pritchett M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Cause state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sykesville Md. DATE OF BURIAL Feb 19 19 23

20 UNDERTAKER J. R. Hess ADDRESS Sykesville

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72519

CERTIFICATE OF DEATH.

90

D72519

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 S. Wolfe. ST., 2 WARD)

2-FULL NAME Andrew Stszempest

(a) RESIDENCE NO. 122 S. Wolfe. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Whi[illegible]	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Andrew Stszempest

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Marcya Nowak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Catharine Stszempest (Address) 122 Wolfe

15 Filed ...19... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1923 to Feb. 13, 1923, that I last saw him alive on Feb 13, 1923 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. William Kupawek, M. D.

(Address) 818 Fremont

2/15/23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 2/16 1923

UNDERTAKER Wm Faltkowski

ADDRESS 148 Ea

MEDICAL CERTIFICATE OF DEATH. PHYSICIANS should be careful in filling out this certificate. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. ACTION is very important. See instructions on back of certificates.

FEB 15 1923

Spec.—1-10-21—M&T—1500 Bks.

CHAMBERS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72520

CERTIFICATE OF DEATH.

11-00

D72520

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 N. Lexington ST., 19 WARD)

2-FULL NAME Mary Eva Chambers

(a) RESIDENCE NO. 1616 N. Lexington St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. — 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER James Chambers

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Annie Williams

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mary Chambers (Address) 1616 N. Lexington St

15 FEB 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1923, to Feb. 14, 1923, that I last saw h alive on Feb 13, 1923, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Influenza + Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James M. Hayes, M. D.

2/15, 1923 (Address) 1046 Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Feb 15 1923

20 UNDERTAKER James A. Adams — ADDRESS 1303 Madison

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D72521 — PLACE OF DEATH — 129 — D72521 REGISTERED NO.

CITY OF BALTIMORE (No. 739 Hemington Ave WARD 13) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Leah S. Walters

(Residence in Baltimore: No. 739 Hemington Ave St.; 50 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: Aug 22 (Month), (Day), 1873 (Year)

7-AGE: 75 yrs. 5 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE (State or country): Virginia

PARENTS

10-NAME OF FATHER: Reed West

11-BIRTHPLACE OF FATHER (State or country): Virginia

12-MAIDEN NAME OF MOTHER: Eliza Parker

13-BIRTHPLACE OF MOTHER (State or country): Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lillian Walters

(Address) 739 Hemington Ave

15

FEB 16 1923 191 ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Feb (Month), 14 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6, 1923, to Feb 13 1923, that I saw h[er] alive on Feb 13 1923, and that death occurred, on the date stated above, at 10.20 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis, Arterio-Sclerosis. ? Uremia

(Duration) yrs. mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Vernon H. Condon, M. D.

Feb 14, 1923 (Address) 750 N. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn

DATE OF BURIAL: Feb 16 1923

20 UNDERTAKER: James B. Ayres

ADDRESS: 1324 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

D72522

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72522

CERTIFICATE OF DEATH.

REGISTERED NO. 141

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1042 N Eden ST., 10 WARD)

2-FULL NAME Eva. M. Braker

(a) RESIDENCE NO. 1042 N. Eden ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. A. Braker

6 DATE OF BIRTH (month, day, and year) Aug. 27 1885

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
37	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John. D. Herbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary. M. Gosman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mr. John. A. Braker

(Address) 1042 N. Eden St

15 Filed FEB 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 14 23

17

I HEREBY CERTIFY, That I attended deceased from February-8. 1923, to February-14. 1923, that I last saw her alive on February-14 1923, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion and Cardiac Failure

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Puerperal Hemorrhage

post partum (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William R. Schwark M. D.

2/15, 1923 (Address) 1200 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Feb. 17 1923

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72523

CERTIFICATE OF DEATH.

31

D72523

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 E Madison ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Jones

(Residence in Baltimore: No. 1509 E Madison St.; 20 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan (Month) 7 (Day), 1903 (Year)

7-AGE, 20 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Edward Harris

11-BIRTHPLACE OF FATHER (State or Country), VA

12-MAIDEN NAME OF MOTHER Charity Murray

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charity Jones (mother)

(Address) 1509 E Madison St

15-

Filed ....., 191.... ROBERT R. KRAMER, Registrar.

FEB 16 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 14 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1923, to Feb 14 1923, that I saw h[er] alive on Feb 13 1923, and that death occurred, on the date stated above, at 10[30] p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB.

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. Young M. D.

2/16, 1923 (Address) 1729 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel cemetery

DATE OF BURIAL, Feb 17, 1923

20-UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72524

CERTIFICATE OF DEATH.

114 D72524

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 N. Exeter St.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hattie ~~Grimby~~ Ninton

(Residence in Baltimore: No. 24 N. Exeter St.; 2 yrs., 6 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should report CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Fem

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: ~~Sept~~ Dec 6, 1920 (Month) (Day) (Year)

7-AGE: 2 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: John Ninton

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Elsie Grimby

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Elsie Grimby

(Address) 24 N. Exeter St.

15-

Filed FEB 16 1923, 191. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb 14, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1923, to Feb 11 1923, that I saw her alive on [illegible] 1923, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) 0 yrs. 0 mos. ds.

(Signed) A. G. Krauss M. D.

2/14, 1923 (Address) 918 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel cemetery

DATE OF BURIAL, Feb 16, 1923.

20-UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72525

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D72525

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 E Fort Ave ST., 24 WARD)

2-FULL NAME Maggie Snyder.

(a) RESIDENCE NO. 602 E Fort Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank. Snyder.

6 DATE OF BIRTH (month, day, and year): Oct 10 1877

7 AGE — Years: 45 — Months: 4 — Days: 3 — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Louis Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Sarah. Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Frank. Snyder. (Address) 602 E Fort Ave

15 Rec'd FEB 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 13th, 1922, to Feb 13, 1923, that I last saw her alive on Feb 13, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Microscopic findings

(Signed) Sidney H. Streett, M. D.

2/14 1923 (Address) 1405 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: 2-17 1923

20 UNDERTAKER: E. B. Harle — ADDRESS: 115 E Wash St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

CERTIFICATE OF DEATH.

D72526

REGISTERED NO. D72526

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 N. Caroline ST. 10 WARD)

2-FULL NAME Mary V. Price.

(a) RESIDENCE NO. 716 N. Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co (State or country) Md.

PARENTS

10 NAME OF FATHER Israel Price.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co., Md.

12 MAIDEN NAME OF MOTHER Caroline Kimball

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Oliver P. Kornmann

(Address) 622 N. Broadway

FEB 16 1923 . 19 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-10, 1923, to 2-13, 1923.

that I last saw her alive on 2-13, 1923

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Double Bronchitis & pneumonia duration, Uncertain, probably at least a week

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Grippe

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) Eleanor E. Price, M. D.

2-14, 1923 (Address) 1012 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Feby 17th 1923

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 Monument St

MARGIN RESERVED, FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72527 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D72527

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 E. Patterson Park ave ST., WARD)

2-FULL NAME Ida O. Fox

(a) RESIDENCE No. 240 E. Patterson Park ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Charles L Fox

6 DATE OF BIRTH (month, day, and year) Oct 12th 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co Md

PARENTS

10 NAME OF FATHER Edward Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co Md

12 MAIDEN NAME OF MOTHER Olivia Spry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co Md

14 Informant Chas L Fox (Address) 240 E Patterson Park ave

15 Filed FEB 16 1923 ROBERT R. KRAUSE, Registrar

*Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 14th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 4th, 1923, to Feb 14th, 1923, that I last saw h[illegible] alive on Feb 14th, 1923 and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Acute Insufficiency

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] Jones, M. D.

Feb 15, 1923 (Address) 1424 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Feby 17th 1923

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument

Spec.—1-10-21 M&T 1500 Bks.

D72528 HEALTH DEPARTMENT—CITY OF BALTIMORE D72528

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Inf. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 1 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Freedman

(a) RESIDENCE NO. 2439 Lakeside ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Freedman

6 DATE OF BIRTH (month, day, and year): 1895

7 AGE — Years: 28 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Bernard Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Dorow Walpert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis (Address): 1434 E Baltimore St

15 Filed FEB 16 1923 19 HUBERT R. KRAUSE Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1922, to Feb 15, 1923.

that I last saw her alive on Feb 15, 1923,

and that death occurred, on the date stated above, at 2:45 p m.

The CAUSE OF DEATH* was as follows:

Liver Abscess

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 8, 1922

Was there an autopsy? No Liver Abscess

What test confirmed diagnosis? Operation

(Signed) Cayetano Santhera M. D.

19 (Address) Church Home and Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem — DATE OF BURIAL: 2/16 1923

20 UNDERTAKER: Jack Lewis — ADDRESS: 1434 E Baltimore St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.–Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72529

HEALTH DEPARTMENT--CITY OF BALTIMORE

(Goldie)

CERTIFICATE OF DEATH

90 D72529

1 PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE (No. 3312 Evergreen Terrace ST. 13 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Louis Goldis

(Residence in Baltimore: No. 3312 Evergreen Terrace St.: 15 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: ..... (Month) ..... (Day), 1890 (Year)

7 AGE: 32 yrs. ..... mos. ..... ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): N. J.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Louis

(Address) 3312 E. Baltimore St.

15 FEB 16 1923, 191 ROBERT R. KRAUTER, Registrar

Burial Permit (Re...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb 15 (Month) (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1923, to Feb. 15, 1923, that I saw h[im] alive on Feb. 15, 1923, and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

Infectious Endocarditis (Streptococcus Viridans)

(Duration) ..... yrs. 6 mos. ..... ds

Contributory (SECONDARY) Myocardial Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Samuel Coolman M. D.

Feb. 16, 1923 (Address) 2444 Eutaw Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Ash Road — DATE OF BURIAL: Feb. 16, 1923

20 UNDERTAKER: Forst Bros. — ADDRESS: 1429 E. Balto.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72530

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72530

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 744 Dolphin ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian M. Lexington

(a) RESIDENCE. No. 744 Dolphin St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of George B. Lexington

6 DATE OF BIRTH (month, day, and year) Nov 19, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert H. Anderson

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah E. Beverly

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Virginia

14 Informant Ida Anderson (Address) 27 N. Vincent St

15 Filed FEB 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 13 11 2 a.m. 1923, to Feb 13 4:30 a.m. 1923

that I last saw h[illegible] alive on Feb 13 4 p.m., 1923,

and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Indigestion (Acute) Duration

(duration) Six and 1/2 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings only.

(Signed) Bunnell Fargo, M. D.

, 19 (Address) 746 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Feb 16th 1923
20 UNDERTAKER	ADDRESS
A. Jones	1114 Gilmor St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72531

100-001

CERTIFICATE OF DEATH.

D72531

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 N Carrollton Ave WARD) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Meredith

(Residence in Baltimore: No. 626 N. Carrollton ave St.; 66 yrs., 10 mos. 16 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 28, 1856 (Month) (Day) (Year)

7-AGE, 66 yrs. 10 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER, John Walter

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Ballmann

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Meredith

(Address) 626 N. Carrollton Ave

15- FEB 18 1923

Filed....., 191.....

ROBERT R. KRAUTER, Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 14, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 10 1923, to Feb 14 1923, that I saw her alive on 14 1923, and that death occurred, on the date stated above, at 10-5 p m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 1 ds.

(Signed) J. Wm. A. Duvall M. D.

4/14, 1923 (Address) 532 Liberty Hgts

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Feb. 17, 1923.

20-UNDERTAKER John F. Denny

ADDRESS 715 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72532

CERTIFICATE OF DEATH.

74-001

D72532

REGISTERED NO. C.....

1 PLACE OF DEATH Md General Hosp

CITY OF BALTIMORE (No. ~~914~~ Kennedy ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John L. Harris Sr

(Residence in Baltimore: No. 1919 Kennedy Av St.; 77 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, ... (Month) Sept (Day) 20, (Year) 1845

7-AGE, ... 77 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert L. Harris

(Address) 2027 Kennedy Av.

15-

Filed ..... 191.....

FEB 16 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb. (Month) 14, (Day) 19 (Year) 23

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Cerebral hemorrhage

.....

..... (Duration) .....yrs. .....mos. 1 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) J. C. Hemmeter M. D.
(Coroner.)

Feb. 15, 1923 (Address) 220 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount	Feb. 17, 1923

20-UNDERTAKER Wm Cook ADDRESS 502 E North

Spec.—1-10-21—M&T—1560 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72533

CERTIFICATE OF DEATH.

129 D72533

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1302 Penna. Ave ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Brooks

(a) RESIDENCE NO. 1302 Penna. Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lee A. Brooks

6 DATE OF BIRTH (month, day, and year) Jan. 8, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	67	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) Private Family

(c) Name of employer Mrs. Grace Fisher

9 BIRTHPLACE (city or town) Easton Shore

(State or country) Accomac Co. Va.

PARENTS

10 NAME OF FATHER William Beccette

11 BIRTHPLACE OF FATHER (city or town) Easton Shore

(State or country) Accomac Co. Va.

12 MAIDEN NAME OF MOTHER Susan Evans

13 BIRTHPLACE OF MOTHER (city or town) Easton Shore

(State or country) Accomac Co. Va.

14 Informant Margaret S. Johnson (Daughter)

(Address) 1302 Penna. Ave.

15 Filed FEB 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13th. 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 28th, 1923, to Feb. 13th. 1923,

that I last saw her alive on Feb. 12th. 1923,

and that death occurred, on the date stated above, at 8:35 p. m.

The CAUSE OF DEATH* was as follows:

Mitral Ins. of unknown origin

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstital Nephritis (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Feb 15 1923

20 UNDERTAKER R. E. Good ADDRESS 1400 McCulloh

Spec.—1-10-21—M&T—1500 Bks.

D72534 HEALTH DEPARTMENT—CITY OF BALTIMORE D72534

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 N. Mount ST., 15 WARD)

2-FULL NAME William Burr

(a) RESIDENCE NO. 1527 N. Mount ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Burr

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co.

PARENTS

10 NAME OF FATHER Aaron Burr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co.

12 MAIDEN NAME OF MOTHER Susie Burr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co

14 Informant Hilda Burr
(Address) 1527 Mount St

15 FEB 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1923, to Feb 13, 1923, that I last saw him alive on Feb 11, 1923 and that death occurred, on the date stated above, at 330 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E. William Frey, M. D.

2/14, 1923 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additioaal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn | DATE OF BURIAL Feb 17 1923

20 UNDERTAKER R. C. Good | ADDRESS 1405 McElderry

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-24—M&T—1500 Bks.

D72535 HEALTH DEPARTMENT—CITY OF BALTIMORE (Dowling) D72535

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 N Gilmor ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas E Dowling

(a) RESIDENCE NO. 220 N Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): Aug 12th 1877

7 AGE: Years 45 | Months 6 | Days 3 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Patrick Dowling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary J Bayden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mary J Dowling

(Address) 220 N Gilmor St

15 FEB 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 21, 1923, to Feb 15 1923.

that I last saw h alive on Feb 13, 1923.

and that death occurred, on the date stated above, at 8.40 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(duration) yrs. 6 mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James L Kelly M. D.

2/16 1923 (Address) 1729 E Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Feb 19 1923

20 UNDERTAKER: John J Fields — ADDRESS: 1200 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DO NOT WRITE IN THIS SPACE RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D72536

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129

D72536

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE—(No. 14 ST. WARD)

2-FULL NAME Rosa Goes Turner

(a) RESIDENCE NO. Somerset Va ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Mortimer A. Turner

6 DATE OF BIRTH (month, day, and year): Dec 4, 1856

7 AGE — Years: 66 — Months: 2 — Days: 12 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Somerset Virginia

PARENTS

10 NAME OF FATHER: Ebenezer Goes.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Albemarle Co. Virginia

12 MAIDEN NAME OF MOTHER: Ann Carter Walker

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Bowl Co. Virginia.

14 Informant (Address): Arthur D. Jones. Montreal apartments

15 FEB 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1923, to Feb 16, 1923, that I last saw her alive on Feb 16, 1923, and that death occurred, on the date stated above, at 12:35 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Norman E Tannenbaum M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Orange, Co — DATE OF BURIAL: Feb 11 1923

20 UNDERTAKER: John O Mitchell — ADDRESS: 1920 N. Fregatt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72537

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72537

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2534 E. Fayette ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas E. Hartwig

(a) RESIDENCE NO. 2534 E. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Hartwig

6 DATE OF BIRTH (month, day, and year): April 7-1876

7 AGE: Years 46; Months 10; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steam fitter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Louis Hartwig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christine Kellein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Mrs. Mary Hartwig 2534 E. Fayette

15 Filed FEB 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1922 to Feb 15, 1923.

that I last saw him alive on Feb 15, 1923,

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Uremia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 4 mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Course

(Signed) Louis Vogel M. D.

, 19 (Address) 1601 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem

DATE OF BURIAL: Feb. 17 1923

20 UNDERTAKER: Jos J. Mehr

ADDRESS: 156 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D72538

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (WARD) 22

(CARDIFF.)

2-FULL NAME Cardiff C. Lyon

(a) RESIDENCE NO. 214 Spalding Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elenor P. Lourdeaux

6 DATE OF BIRTH (month, day, and year): Dec. 31, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William V. Lyon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Cordelia C. Beckmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Hospital Records Corrected by Edgar Lyon 3 Greenway

FEB 16 1923 Filed, 19

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 16, 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1922, to Feb. 16, 1923, that I last saw him alive on Feb. 16, 1923, and that death occurred, on the date stated above, at 1:35 a m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) Sudden mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms & Signs.

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: 2/17 1923

20 UNDERTAKER: Henry W. Means & Son

ADDRESS 800 N. Calvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72539

D72539

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Myrtle Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Smith

(a) RESIDENCE. No. 1312 Myrtle ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) March 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eston Shore md

12 MAIDEN NAME OF MOTHER Armenster Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eston Shore md

14 Informant Lorraine Perry

(Address) Roland Park Baltimore co

15 Filed FEB 18 1923 . 19 ROBERT N. KRAUTER, Burial Permit Clerk. Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 11 , 1923 , to Feb 14 , 1923 ,

that I last saw h.. alive on Feb 14 , 1923 ,

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Paralysis + Old age

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) F. D. Wardlaw , M. D.

2-14 1923 (Address) 703 Mt Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 17 1923
20 UNDERTAKER	ADDRESS
Geo Roest + Elliott	1725 Ashland ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72540 — CERTIFICATE OF DEATH. Holt 174-001 — D72540

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: NO. 850 McClain ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Holt

(a) RESIDENCE. NO. 850 McClain ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Aug 9 1893

7 AGE — Years: 29 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city

PARENTS

10 NAME OF FATHER: John Yates

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Laura Yates

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Bertha Yates
(Address) 850 McClain St

15 Filed FEB 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 1923, to Feb 12 1923, that I last saw h[illegible] alive on Feb 12 1923, and that death occurred, on the date stated above, at 1 45 m.

The CAUSE OF DEATH* was as follows:

Apoplexy
3 hours (duration) ... yrs. ... mos. 3 hours ds.

CONTRIBUTORY (Secondary): Epilepsy
(duration) 12 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J Edward Fisher, M. D.

2-13 1923 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Feb 16 1923

20 UNDERTAKER: Mrs. R. C. Ellis — ADDRESS: 172 Caroline

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72541

CERTIFICATE OF DEATH.

129 D72541

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 West Echodale Ave St.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Ella Sunwalt

(Residence in Baltimore: No. 12 W. Echodale Ave St.; Lifelong yrs. mos. ds.)

N. B.—THIS IS A PERMANENT RECORD AND SHOULD BE WRITTEN WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, April (Month) 31 (Day), 1846 (Year)

7-AGE, 56 yrs. 9 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, John Finch

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. F. Wiesnicke

(Address) 12 W. Echodale Ave.

15- FEB 16 1923 rec'd ....., 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Febry (Month) 16 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Febry 12 1923, to Febry 16 1923, that I saw her alive on Febry 3 1923, and that death occurred, on the date stated above, at ? m.

The CAUSE OF DEATH* was as follows: See note on back.

(a) Paralysis General

(Duration) 2 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 4 yrs. 6 mos. 6 ds.

(Signed) George C. Shannon M. D.

2/16, 1923 (Address) 702 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, Feb 17, 1923

20-UNDERTAKER George J. Smith

ADDRESS 1532 Hollins

Spec.—1-10-21—M&T—1500 Bks.

D72542

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 D72542

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 711-East-21st-St. (St.) (9) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Ellsler

(a) RESIDENCE NO. 711-East-21st-St. ST., 9 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 94 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? 94 yrs. 2 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Ellsler

6 DATE OF BIRTH (month, day, and year) Nov-18-1828

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	94	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Snyder

11 BIRTHPLACE OF FATHER (city or town) York
(State or country) Penna

12 MAIDEN NAME OF MOTHER Harriet Webb

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co
(State or country) Maryland

14 Informant Mr. Geo. R. Ellsler (son)
(Address) 711-E-21st-St. City

15 Filed FEB 16 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1923 to Feb 14 1923

that I last saw h[illegible] alive on Feb 14 1923

and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) — yrs. — mos 29 ds.

CONTRIBUTORY (Secondary) Heart failure Exhaustion

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL GREEN MOUNT CEMETERY

DATE OF BURIAL Feb-17-[illegible]

20 UNDERTAKER STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72543

CERTIFICATE OF DEATH.

D72543

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Emma Williams

(Residence in Baltimore: No. 3 N. Caroline St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH, Sept (Month) 7 (Day) 1921 (Year)

7-AGE, 1 yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto md

PARENTS.

10-NAME OF FATHER, Austin Williams

11-BIRTHPLACE OF FATHER, (State or Country), S. Carolina

12-MAIDEN NAME OF MOTHER, Lillie Alston

13-BIRTHPLACE OF MOTHER, (State or Country). S. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins

(Address) Hospital

15-

Filed FEB 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 15 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) .....yrs.....mos. 5 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) .....yrs.....mos. 1 ds.

(Signed) C. S. Collier M. D. (Coroner.)

2-17 1923 (Address) 5 E 6 Eutaw

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. JOHNS HOPKINS HOSPITAL DATE OF BURIAL. FEB 15 1923

20-UNDERTAKER. Commissioner Health. ADDRESS

Per. Wm. E. WOODALL

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72544

101-001

D72544

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Brady

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Henry Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from February 11 1923 to February 13 1923, that I last saw him alive on February 13, 1923, and that death occurred, on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

2-13-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL 2/16 1923

20 UNDERTAKER Mrs. M. Fink ADDRESS 1737 W Pratt St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D72545

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72545

CERTIFICATE OF DEATH.

36

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1837 Light ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Engel

(a) RESIDENCE NO. 1837 Light ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Belle Engel

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
77	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co Md

PARENTS

10 NAME OF FATHER: Peter Engel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Hannah Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Engel. (Address) 1837 Light.

15 Filed 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-15-1923

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1922, to Feb. 15, 1923.

that I last saw him alive on Feb. 15, 1923.

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of kidneys, prostate, ureters, bladder and urinary tract

(duration) about 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tuberculosis bacteriological

(Signed) Howard L. Folsom M. D.

19 (Address) 1325 E. Oakland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Md — DATE OF BURIAL: 2/18 1923

20 UNDERTAKER: I. Frew McCully — ADDRESS: 130 E. Front

DEC 16 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72546

CERTIFICATE OF DEATH.

90 D72546

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1145 Riviere ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Gardner

(a) RESIDENCE NO. 1145 Riviere ST., 24 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm D. Gardner

6 DATE OF BIRTH (month, day, and year): Oct 14/1849

7 AGE — Years: 73 — Months: 4 — Days: 26 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Joseph Carver

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Brawn Gardner

(Address) 3415 Mondawmin

15 Filed: Feb 16 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1923, to Feb 15, 1923, that I last saw him alive on Feb 14, 1923, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Independent (duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Acute Dilatation of Heart (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. R. L. Campbell M. D.

Feb 15, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: 2/17 1923

20 UNDERTAKER: J. F. McCully

ADDRESS: 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72547 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D72547

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 14 N.ANN St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.) Life

2-FULL NAME Catherine B. Flaherty

(Residence in Baltimore: No. 14 N ANN St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
female	white	single

6-DATE OF BIRTH. 848
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
75 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer): music teacher

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm.Flaherty

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Mary A Murphy

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Glenn

(Address) Colgate Md.

15. Filed FEB 16 1923 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 14/23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably a cardiac failure
Found dedd in her rooms. NO evidence of violence. Lived a hermit's life

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J S H Owen M. D.
(Coroner)

2-16 1923 (Address) 506 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Patricks	Feb 17 1923
20-UNDERTAKER.	ADDRESS
Richard F Cusley	438 E North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72548

CERTIFICATE OF DEATH.

65-001 D72548

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 528 Beaumont ave ST., (WARD) Govans

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kuper

(a) RESIDENCE No. 528 Beaumont ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31-1916

7 AGE — Years: 7 — Months: — — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER C. Albert Kuper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Estella Klug

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant C. Albert Kuper

(Address) 528 Beaumont ave

Filed FEB 15 1923 Robert P. Harrison Registrar

Burial Permit 07201

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 15 1923

17 I HEREBY CERTIFY, That I attended deceased from — 1920 to Feb 15 1923

that I last saw h alive on Feb 15 1923,

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Splenomyelogenous Leukaemia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood exam.

(Signed) John Rubrah M. D.

(Address) 11 E Chase St

Feb 16 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 2/17 1923

20 UNDERTAKER: Chas. B. Evans & Son

ADDRESS: 1101 Mt Royal Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72549

CERTIFICATE OF DEATH.

100-001

D72549

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 944 (Street) Bennett Place (Ward) 18

2-FULL NAME Margaret Eileen O'Brien

(a) RESIDENCE No. 944 Bennett Place ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 1st 1922

7 AGE — Years — Months 14 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Dominick O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Dominick O'Brien

(Address) 944 Bennett Place

FEB 16 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1923 to Feb 15th 1923 that I last saw h-e alive on Feb 15th 1923 and that death occurred, on the date stated above, at 10 30/11 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary): Acute tracheitis

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J Sullivan, M. D.

2/15 1923 Address 1701 Eutaw and

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Feb 17th 1923

20 UNDERTAKER: H. Brannigan & Co

ADDRESS 517 N. Schroeder St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Mundy) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72550

D72550

CERTIFICATE OF DEATH.

11-002

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 38 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Mary Mundy

(a) RESIDENCE. No. Mount Hope Retreat ST., 28th WARD. Wilmington Del

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greenville Del

PARENTS

10 NAME OF FATHER Wm J. Mundy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wilmington Del.

12 MAIDEN NAME OF MOTHER Mary A. Ralston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Oakland Del

14 Informant (Address) Records of Mt. Hope Retreat Wilm. Del.

15 Filed , 19 Registrar

Robert P. Anthony

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1923, to Feb 16, 1923, that I last saw h alive on Feb 15, 1923, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Encephalitis - Post Flu infection -

(duration) 0 yrs. 0 mos. 17 ds.

CONTRIBUTORY (Secondary) Acute Mania

(duration) 0 yrs. 0 mos. 17 ds.

18 Where was disease contracted if not at place of death? Hockessin Del-

Did an operation precede death? Uno Date of

Was there an autopsy? Uno

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington Del.

DATE OF BURIAL 2/16 1923

20 UNDERTAKER Chas F. Evans & Son

ADDRESS 118 W. 11th Royal Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72551 D72551

101-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2167 N Mount ST., 19 WARD)

2-FULL NAME Annie D Harris

(a) RESIDENCE NO. 2167 N Mount ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Joseph Harris

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General House Work

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Raleigh NC

PARENTS

10 NAME OF FATHER: Charles Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Howard Harris 1605 W Saratoga

15 Filed FEB 16 1923, 19 Robert F. Leyhe Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 14 1923 to Feby 15 1923 that I last saw h alive on Feby 15 1923 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. T. Howard M. D.

2/15/1923 (Address) 1191 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hannastown Md — DATE OF BURIAL: Feb 17 1923

20 UNDERTAKER: John H Owens — ADDRESS: 5338 Belair Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72552

CERTIFICATE OF DEATH.

REGISTERED No. C 170

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1124 So. First St.) (No. 26 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Dasch
(Residence in Baltimore. No. 1122 So. First St.)
(St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Dec 23rd, 1876
(Month) (Day) (Year)

7-AGE. 46 yrs. 1 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER, Adam Dasch

11-BIRTHPLACE OF FATHER (State or Country). Portugal Md.

12-MAIDEN NAME OF MOTHER Elizabeth Fradich

13-BIRTHPLACE OF MOTHER (State or Country). Ireland Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Dasch
(Address) 1122 So. First St Balto

15- Robert P. Harrison
Filed ..... 191.....
Registrar.

FEB 16 1923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 14th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry
(Inquest, au
.....find that said deceased came to.....death
topsy or inquiry.)
on the day stated above.
The CAUSE OF DEATH* was as follows:
Hemorrhage Brain
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) Thos. B. Horton M. D.
(Coroner)
Feb 15 1923 (Address) Curtis Bay Md

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sacred Heart Cem. DATE OF BURIAL, Feb 17 1923.

20-UNDERTAKER Lilly & Feiler ADDRESS No 3 S Wolfe St.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Blks.

D72553

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72553

139

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary E. Brown

(a) Residence No. 1013 E. Madison St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): June 6 1874

7-AGE: 48 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Mary Land

PARENTS:
10-NAME OF FATHER: William Wewer
11-BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina
12-MAIDEN NAME OF MOTHER: Maria Grass
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Mary Land

14-
(Informant).....
(Address) Hospital Records

15-
Filed FEB 18 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): FEB 14 '23

17- I HEREBY CERTIFY, That I attended deceased from Jan. 25 19 23 to Feb 14 19 23

that I last saw h[er] alive on Feb. 14 19 23

and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Uterine Fibroids. (infected)

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) G. U. Sepsis

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-13-23

Was there an autopsy? Yes Supra Vaginal Section

What test confirmed diagnosis? Operation & autopsy findings

(Signed) E. J. Sessford M. D.

19 (Address) 1 Mt. Vernon Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Zion Cemetery Govans	Feb. 18 1923
20-UNDERTAKER.	**ADDRESS**
Mrs. Jos. H. Locks.	432 Jefferson st.

FILL IN PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Infection Unknown

Spec.—1-10-21—M&T—1500 Bks.

D72554

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72554

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 N Linwood ave ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Young

(a) RESIDENCE NO. 746 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Young

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Carl Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: H. C. Witty

(Address): 126 N Linwood ave

15 Filed Feb 16 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 5 1923 to Feby 14 1923, that I last saw her alive on Feby 14 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Grippe

Broncho-Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. D. Collenberg, M. D.

Feby 16 1923 (Address) 1810 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: Feb 17 1923

20 UNDERTAKER: Louis Heemann ADDRESS: 325 Broadway

A—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B 16 1923

Spec.—1-10-21—M&T—1500 Blks.

D72555

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X100-00 D72555

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 N Potomac ST., 6 WARD)

2-FULL NAME Annie Elizabeth Calvert

(a) RESIDENCE NO. 130 N Potomac ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 5 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W Calvert

6 DATE OF BIRTH (month, day, and year) April 10 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	77	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at

(b) General nature of industry, business, or establishment in which employed (or employer) home

(c) Name of employer

9 BIRTHPLACE (city or town) Lake Shore
(State or country) A.A.Co Maryland

PARENTS

10 NAME OF FATHER P. Blunt

11 BIRTHPLACE OF FATHER (city or town) Kent Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER A Longfellow

13 BIRTHPLACE OF MOTHER (city or town) Kent Co
(State or country) Maryland

14 Informant Perry B Calvert
(Address) 140 N Potomac St

15 Robert F. Harrison. ..... 19 .....
Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1 —, 1923, to Febr. 15 —, 1923, that I last saw her alive on Febr. 15 —, 1923, and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs ... mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Philibert Artigiani, M. D.

2/11, 1923 (Address) 2942 Fayette st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Magothy M.E. Church Cemetery — DATE OF BURIAL Feb 17 1923

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

FEB 16 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-00 D72556

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2403 West Franklin ST., 20 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A. Buck

(a) RESIDENCE No. 2403 West Franklin ST., ... WARD ...
(Usual place of abode)
Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rosa May Buck

6 DATE OF BIRTH (month, day, and year) Mar 27-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work American Dye Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Dye business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Maryland

PARENTS

10 NAME OF FATHER Bachman Buck

11 BIRTHPLACE OF FATHER (city or town) (State or country) United States

12 MAIDEN NAME OF MOTHER Mary E. Buck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Maryland

14 Informant (Address) Rosa May Buck 2403 West Franklin

15 FEB 16 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1923 to Feb. 14, 1923.

that I last saw h in alive on Feb. 14, 1923

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Franklin & Pulaski

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) A. Frederick Stumpf, M. D.

2/15, 1923 (Address) 3310 W. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL 2/17/ 1923

20 UNDERTAKER Em. Wilson & Son ADDRESS 2503 Edmondson ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72557

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72557

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 Riggs Ave. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose White

(a) RESIDENCE. No. 1516 Riggs Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Late Levi White

6 DATE OF BIRTH (month, day, and year) Oct. — 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer): General housework Paid servitude

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co. Md.

PARENTS

10 NAME OF FATHER John Benson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co Md.

14 Informant Ella Satchell

(Address) 1516 Riggs ave.

15 Robert P. Harrison, 19

Registrar

Burial Permit Clerk.

FEB 16 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1923, to Feb 14, 1923, that I last saw her alive on Feb 14, 1923, and that death occurred, on the date stated above, at 5-20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. L. McCardell, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem	2-17-23
20 UNDERTAKER. Daniel Carter	ADDRESS 916 Druid

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72558 — 129 — D72558

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen. Hospital ST.; 4 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr Charles H.P. Coe

(Residence in Baltimore: No. 15 Pearl St St.; 62 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb 21 (Month) (Day), 1861 (Year)

7-AGE, 61 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Retired

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jessie Coe Bowen

(Address) 15 N Pearl St

15- Filed ....., 191.....

Robert F. Harrison, Registrar.

Burial Permit Clerk.

16 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 15 (Month) (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1923, to Feb 15 1923, that I saw him alive on Feb 15 1923, and that death occurred, on the date stated above, at 4.25 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

not known

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James Hutchinson M. D.

Feb 16, 1923 (Address) Md General Hospt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Bolton Cem

DATE OF BURIAL, Feb 17, 1923

20-UNDERTAKER J J Foley Sons

ADDRESS 318 Fayette St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72559

D72559

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 Clifton & Balto ST., 15 WARD)

2-FULL NAME Amanda Lucabaugh.

(a) RESIDENCE NO. 1811 Clifton & Balto ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 93 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amanda Lucabaugh

6 DATE OF BIRTH (month, day, and year)

7 AGE: 87 Years — Months — Days

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Harry Hinkleman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Susan Haines

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: James Lucabaugh
(Address) 1811 Clifton

15 Filed FEB 16 1923 Robert P. Harris, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14. 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-1-, 1923, to 2/14., 1923, that I last saw h[er] alive on 2/10—, 1923 and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis

(duration) 2 yrs. 5 mos — ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Urinary Exam

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Freedom Cemetery. Pa. DATE OF BURIAL: Feb 17 1923

20 UNDERTAKER: Geo. F. Ruth ADDRESS: 1735 Harford Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72560

CERTIFICATE OF DEATH.

11-001 D72560

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2038 E. Eden · ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Maffre

(Residence in Baltimore: No. 2035 E. Eden · St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
M	W.	Single

6-DATE OF BIRTH, Nov 20, 1921
(Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Italy

PARENTS.

10-NAME OF FATHER, Samuel Maffre

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rose Malena

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Maffre

(Address) 2035 E. Eden

15-

Filed ....., 191.. Robert P. Harrison, Registrar.

Burial Permit Clerk

FEB 16 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 14, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 2 1923, to Feb 14 1923, that I saw h[illegible] alive on Feb 14 1923, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Influenza 28 days

(Duration) ....yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

2-16-, 1923 (Address) 1038 E. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Holy Rood Cem. DATE OF BURIAL, Feb 17, 1923

20-UNDERTAKER Wendell Lippold & Co. ADDRESS 21 S. Conkt

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

Freund ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72561

CERTIFICATE OF DEATH.

14-00 D72561

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Theodora Freund

(Residence in Baltimore: No. Dorguth St & Maryland Ave St.; 41 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, March 7, 1850
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
72 yrs. 10 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic Work
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, Charles Freund

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Griesbaber

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sister Mary Dionetta

(Address) Notre Dame Dorguth St

15- Robert P. Harris, M.D., 191.....
Burial Permit Clerk. Registrar.

B 161923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 15, 1913.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1912, to Feb 15 1913, that I saw h.. alive on Feb 15 1913, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Epithelioma Tongue
Metastasis Lymphatic Glands
Exhaustion

(Duration) 5 mos.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Kuhn M. D.

Feb 16, 1913. (Address) 110 E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL.
Natchcliffe Md.	Feb. 17, 1913
20-UNDERTAKER	ADDRESS
Frank E. Fink	916 N. Gay St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72562

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72562

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2732 Harlem Ave St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Vincenzo Alagna

(Residence in Baltimore: No. 2732 Harlem Ave St.; yrs. 2 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Single

6-DATE OF BIRTH. Nov. 28th (Month) (Day) 1921 (Year)

7-AGE.	If LESS than 1 day.
1 yrs. 2 mos. 17 ds.	....hrs. or....mts.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER Giuseppe Alagna

11-BIRTHPLACE OF FATHER, (State or Country). Italy

12-MAIDEN NAME OF MOTHER Francesca Culotta

13-BIRTHPLACE OF MOTHER, (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Giuseppe Alagna

(Address) 2732 Harlem Ave

15- FEB 16 1923

Robert P. Hartman

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 15, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ....yrs. ....mos. ....ds.

(Signed) D. E. Hammond M. D.
(Coroner.)

Feb. 16 1923 (Address) 2702 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cem	2/17/23 19

20-UNDERTAKER.	ADDRESS
Geo. J. Path	1205 Hanford Ave.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72563

CERTIFICATE OF DEATH.

159-08

D72563

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 E Lanvale ST.: 8 WARD)

2-FULL NAME Virginia C. Allers

(a) RESIDENCE. No. 1717 E Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Herman S Allers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Co

12 MAIDEN NAME OF MOTHER Matilda Crane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Co

14 Informant Herman S Allers
(Address) 1717 E Lanvale

15 Robert P. Harrison, Registrar

B 16 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1923, to Feb 15, 1923, that I last saw her alive on Feb 15, 1923 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Congestive Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John O'Arcy, M. D.

, 19 (Address) 1603 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Feb 17 1923

20 UNDERTAKER: E LeRoy Stiffler — ADDRESS: 852 Mott Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72564

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72564

CERTIFICATE OF DEATH.

100-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 N. Ellwood Ave. WARD 6)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Volenowsky.

(a) RESIDENCE No. 126 N Ellwood Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Feb 2nd 1922

7 AGE — Years: 1 — Months: 11 — Days: 13 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Frank Volenowsky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Nellie Hart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs Nellie Volenowsky

(Address) 126 N Ellwood Ave

15 Filed Feb 16 1923 Robert P. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13 1923 to Feb 15 1923 that I last saw h[illegible] alive on Feb 15 1923 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) [illegible] M. D.

Feb 16 1923 (Address) 1000 Hull St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Feb 16 1923

20 UNDERTAKER: Geo M. Hunt & Son — ADDRESS: 811 W Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

16 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72565 D72565

CERTIFICATE OF DEATH.

89

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3419 Jonquil Ave ST., 27 WARD)

2-FULL NAME Edwin F. Hall

(a) RESIDENCE NO. 3419 Jonquil Ave ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	67	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Hall
(Address) 3419 Jonquil Ave

15 Filed FEB 16 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1923, to Feb 16, 1923, that I last saw him alive on Feb 11, 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Charles J Neal, M. D.

, 19 (Address) 2 W Belvedere Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Glenwood Md — DATE OF BURIAL: Feb 18 1923

20 UNDERTAKER: W. C. Brooks — ADDRESS: Sparrows Md

B 16 1923

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72566 HEALTH DEPARTMENT—CITY OF BALTIMORE D72566

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. Grace Baptist Church St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Houston

(Residence in Baltimore: No. 1529 N. Eden St.; yrs. 58 mos. 7 ds. 10)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): M

6-DATE OF BIRTH: Aug 4 1864 (Month) (Day) (Year)

7-AGE: 58 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Carpenter (b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Alex. B. Houston

11-BIRTHPLACE OF FATHER, (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Susanna Sheckells

13-BIRTHPLACE OF MOTHER, (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Annie Wilkerson

(Address) 1529 N. Eden

15- Robert P. Harrison

Filed FEB 16 1923 192 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb 14 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis Chronic Endocarditis

P (Duration) 12 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

several yrs ago (Duration) yrs. mos. ds.

(Signed) J. S. H. Cotter M. D. (Coroner.)

2-1 192 (Address) 518 E. Fort Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Green Mount Cemetery 2/17 1923.

20-UNDERTAKER. ADDRESS

Liston P. Fussellaugh 2620 St Paul St.

28—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72567

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D72567

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) St Agnes Hosp. ST. 27 WARD)

2-FULL NAME Rev. John Andrew Boyd

(a) RESIDENCE NO. St Michaels Orleans Md

(Usual place of abode) WARD

Length of residence in city or town where death occurred about 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 28th 1869

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
53	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Priest

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delware

PARENTS

10 NAME OF FATHER Andrew Boyd.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Fox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Lennie Moran

(Address) 2000 E. Balto. St.

15 Filed Robert P. Harrison, Registrar

16 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1923, to Feb. 15, 1923.

that I last saw h[illegible] alive on Feb. 15, 1923.

and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis -
Myocarditis - Hypertension
apoplexy -

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure - Pulmonary Oedema.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? no -

What test confirmed diagnosis? Clinical

(Signed) J. J. Coldwell M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashland Va.

DATE OF BURIAL 2/19 1923

20 UNDERTAKER John A Moran

ADDRESS 2000 E. Balto St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D72568 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 D72568

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 107 S. Carlton St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Dahl (Dahl)

(Residence in Baltimore: No. 107 S. Carlton St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Jan (Month) 28 (Day) 1923 (Year)

7-AGE. .....yrs. .....mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balt City

PARENTS.

10-NAME OF FATHER. Alexander Dahl

11-BIRTHPLACE OF FATHER. (State or Country). Balt

12-MAIDEN NAME OF MOTHER. Margaret Dawson

13-BIRTHPLACE OF MOTHER. (State or Country). Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexander Dahl

(Address) 107 S Carlton

15- Filed JAN 17 1923 Robert P. Harrison, 192..... Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Jan (Month) 16 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) .....yrs. .....mos. 6 ds.

(Signed) James M Fenton M. D.
(Coroner.)

Jan 17 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mount Olivet	Jan 17 1923

20-UNDERTAKER.	ADDRESS
John J Fields	1200 W Fayette St

U.S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72569

CERTIFICATE OF DEATH.

129 D72569

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1220 Hollins St. ST., 18 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Doughty

(a) RESIDENCE NO. 1220 Hollins St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nehemiah Doughty

6 DATE OF BIRTH (month, day, and year) Aug. 29th 1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
66	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Whiteford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa/

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Joseph Whiteford

(Address) 1220 Hollins St.

15 Filed Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/13/23, 19, to 2/15/23 19, that I last saw h alive on 2/15/23, 19, and that death occurred, on the date stated above, at 10.30P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chron. Ad. Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

2/16 19 23 (Address) 1302 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL Feb 19 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D72570

CERTIFICATE OF DEATH

91-002 D72570

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 613 N. Calhoun St ST. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Jennie Elizabeth Barnes

(Residence in Baltimore: No. 613 N. Calhoun St St.: 55 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Feb (Month) 22 (Day), 18[illegible] (Year)

7 AGE: 73 yrs. 11 mos. 23 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Nothing
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9 BIRTHPLACE (State or country): Frederick, Md.

PARENTS

10 NAME OF FATHER: [illegible] Elizabeth Barnes

11 BIRTHPLACE OF FATHER (State or country): Frederick, Md.

12 MAIDEN NAME OF MOTHER: [illegible] Bartgis

13 BIRTHPLACE OF MOTHER (State or country): Frederick, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [illegible] Lee Stone

(Address) 613 N. Calhoun St

15 Feb 17 1923

Robert P. Garrison, Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 14 (Day), 191[illegible] (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 191[illegible], to. Feb 14 191[illegible].

that I saw h[illegible] alive on ....., 191[illegible].

and that death occurred, on the date stated above, at 6 [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral uremic Sclerosis

(Duration) 7 yrs. mos. ds

Contributory (SECONDARY) Status Pneumonic

(Duration) yrs. mos. 14 ds.

(Signed) Dr. Jacob H. Lee M. D.

Feb, 191[illegible] (Address) 700 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loraine Cemetery

DATE OF BURIAL: Feb 17 1923

20 UNDERTAKER: Joseph B Cook

ADDRESS: 1003 N Bolton St.

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72571

CERTIFICATE OF DEATH.

46 D72571

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 57 S. Monroe St. ST., 19 WARD)

2-FULL NAME Emma Jane Weaver

(a) RESIDENCE NO. 57 S. Monroe St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dederick C. Weaver

6 DATE OF BIRTH (month, day, and year) Feb. 22" 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	69	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Columbus C. Mc Daniel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Drusilla ?

13 BIRTHPLACE OF MOTHER (city or town) Kent Co.
(State or country) Md.

14 Informant Emma D. Townsend
(Address) 57 S. Monroe St.

15 Filed [illegible] 19
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16" 1923

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1922, to Feb 16, 1923.

that I last saw her alive on Feb 16, 1923

and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Inoperable Carcinoma Cervix ?

2 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Theo Kalamaras M. D.

2/16 1923 (Address) Hollins & Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL Feb. 19 1923

20 UNDERTAKER Joel B. Cook ADDRESS 1003 W. Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D72572

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72572

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. #712 S. Wolfe St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Bella Leeman

(a) Residence No. 712 S. Wolfe St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph

6-DATE OF BIRTH (month, day and year) Nov 20 1863

7-AGE, 70 yrs. 2 mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House Keeping

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 0

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Don't know

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Poland

14- (Informant) Wendell Dippel

(Address) 37 S. Ann St

15-

Filed ..... Robert F. Harris Registrar.

FEB 17 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 16 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 1922 to Feb 16 1923

that I last saw h alive on Jan 15 1923

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Kyle M. D.

2/17, 19 (Address) 712 S. Wolfe St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross Cemetery — DATE OF BURIAL. Feb 19 1923

20-UNDERTAKER. Wendell Dippel & Son — ADDRESS 37 S Ann

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D72573

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72573

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 E Hamburg ST., 7th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hildia A. Catterton

(a) RESIDENCE No. 222 E Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 14 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Chas R. Catterton

11 BIRTHPLACE OF FATHER (city or town) Calvert Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Essie M Minster

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co (State or country) Maryland

14 Informant Charles R Catterton

(Address) 222 E Hamburg

15 Filed 1923 Robert P. Carrington Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923, to Feb 16, 1923

that I last saw h alive on Feb 16, 1923

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H. K. Campbell M. D.

Feb 16, 1923 (Address) 1644 Harlem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Chapel Cemetery Calvert Co Md

DATE OF BURIAL Feb 17 1923

20 UNDERTAKER John F Dorsey

ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72574

CERTIFICATE OF DEATH.

129 D72574

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3029 Hudson ST., 1 WARD)

2-FULL NAME Henry Buddemeier

(a) RESIDENCE NO. 3029 Hudson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fredericka Buddemeier

6 DATE OF BIRTH (month, day, and year) July 2, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	79	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer 034

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Buddemeier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Fredericka Buddemeier (Address) 3029 Hudson St

15 Filed Feb 19 1923 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1923, to Feb 15, 1923, that I last saw h[illegible] alive on Feb 15, 1923 and that death occurred, on the date stated above, at 2.45 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Senility old age

Chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. A. Meyer Jr., M. D.

2/5, 1923 (Address) N 38 E Baker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul Cemetery — DATE OF BURIAL Feb 18 1923

20 UNDERTAKER H. Sander Sons — ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72575

CERTIFICATE OF DEATH.

90 D72575

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 501 S. 3rd St. ST.; 16 WARD)

2-FULL NAME Frederick W. Zimmerman

(a) RESIDENCE. No. 501 S. 3rd St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Letter Carrier

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Eckhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Elizabeth Wager.
(Address) 501 S 3rd St.

15 Filed . 19 Registrar

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/15 — 1923

17

I HEREBY CERTIFY, That I attended deceased from May 1st, 1922, to Febr. 15 —, 1923,

that I last saw him alive on Febr. 15 —, 1923

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Artigiani, M. D.

2/15 1923 (Address) 2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	19
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 E. Lat St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16/618
D72576

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D72576

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Hickman.

(a) RESIDENCE NO. 738 W. Fayette St. City, ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced (or) WIFE of William Hickman (Husband) Same address

6 DATE OF BIRTH (month, day, and year) Feb. 21-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. (37)

(b) General nature of industry, business, or establishment in which employed (or employer) (4)

(c) Name of employer (4)

9 BIRTHPLACE (city or town) (State or country) (4) Maryland

PARENTS

10 NAME OF FATHER Albert Massey (4)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Virginia Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (4) Md.

14 Informant (Address) JOHNS HOPKINS HOSPITAL. Baltimore

15 FEB 17 1923 Robert P. Hartman, M.D. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February-16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1923, to Feb 16, 1923, that I last saw her alive on Feb 16, 1923, and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Uremia

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) S. Conkey Adams, M. D.

2/16/23 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Feb. 19, 1923

20 UNDERTAKER N. E. Viles — ADDRESS 329 Md Ave Westport.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Gabrio)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72577

101-60 D72577

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 S Monroe ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Gabrio

(a) RESIDENCE. NO. 205 S Monroe ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: Louis Gabrio

6 DATE OF BIRTH (month, day, and year): Jan 8 - 1857

7 AGE: Years 66 | Months 1 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework (?)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Christian Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Louis Gabrio 205 S. Monroe St

15 Filed Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1923 to Feb 15, 1923, that I last saw h[illegible] alive on Feb 15, 1923, and that death occurred, on the date stated above, at 11.45 A.M.

The CAUSE OF DEATH* was as follows:

Toxaemia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Labor Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly M. D.

(Address) 1st Feb 16, 1923 [illegible] Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park | DATE OF BURIAL: Feb. 19 1923

20 UNDERTAKER: Geo. L. Schroab | ADDRESS: 710 Eutaw St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72578

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D72578

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Lenox ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William D. Seibel

(a) RESIDENCE. No. 510 Lenox ST., 21 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~ Married, Widowed, ~~or Divorced~~ (write the word)
Male	White	Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Agnes Seibel

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER Adam Seibel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant Anna L. Mathews
(Address) 510 Lenox St

15 1923 Robert F. Garrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1923, to Feb 14, 1923, that I last saw h— alive on Feb 14, 1923, and that death occurred, on the date stated above, at 9:40 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) — yrs. — mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Gruenbaum, M. D.

2/14, 1923 (Address) 51 Lenox St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery Co	Feb 19th 1923
20 UNDERTAKER	ADDRESS
Geo Leimbach & Son	647 W. Baltimore St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1/7 1923

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72579

CERTIFICATE OF DEATH.

10 4001 D72579

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Walbrook Apt

CITY OF BALTIMORE: (NO. Walbrook Ave ST., Edgewood 45 WARD)

2-FULL NAME George Edward Pickering

(a) RESIDENCE NO. Walbrook Apartment ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Ida Shaw Pickering

6 DATE OF BIRTH (month, day, and year) Sept 23 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer 042

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John N. Pickering

11 BIRTHPLACE OF FATHER (city or town) (State or country) Portsmouth N. H

12 MAIDEN NAME OF MOTHER Vara B Isbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Haven Conn

14 Informant John N Pickering (Address) Walbrook Apt

15 Filed FEB 17 1923, 19 Robert F. Barry (Registrar)

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 15" 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 8" 1923 to Feby 15" 1923, that I last saw h alive on Feby 15" 1923 and that death occurred, on the date stated above, at 9.05 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Both Lungs)

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. R. Duvall, M. D.

3/6 1923 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Feb 17 19 23

20 UNDERTAKER Wm J. Tickner & Sons — ADDRESS Norfolk Va

N. B.—WRITE PLAINLY WITH CARBON INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72580

CERTIFICATE OF DEATH.

23 D72580

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2527 Shirley Ave. St.) 15 WARD)

2-FULL NAME George H. Bald

(a) RESIDENCE NO. 2527 Shirley Ave. ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Bald

6 DATE OF BIRTH (month, day, and year) July 1- 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	44	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector (Health Dept.)

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Balto. City Health Dept.

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Wm. Bald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Pauline Kline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Chas. W. Bald

(Address) Beulah & Park Hts. Ave.

15 Filed ..... 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from January 31, 1923, to Feb. 15, 1923, that I last saw him alive on Feb. 15, 1923, and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lethargic Encephalitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Signs

(Signed) Frank H. Machin M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Feb 19 1923

20 UNDERTAKER Wm J Tickner & Sons ADDRESS N. Y. Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 17 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72581 101-001 D72581

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1338 N Calhoun ST., 15 WARD)

2-FULL NAME Frank Holmes

(a) RESIDENCE NO. 1338 N Calhoun ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Ida Holmes

6 DATE OF BIRTH (month, day, and year): Oct 5, 1889

7 AGE — Years: 33 — Months: 4 — Days: 8 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Brickyard

(c) Name of employer: Geo Washburn

9 BIRTHPLACE (city or town) (State or country): Albemarle Ct Va

PARENTS

10 NAME OF FATHER: Jessie Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C

12 MAIDEN NAME OF MOTHER: Julia Wooster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charlottesville Va

14 Informant: Ida Holmes
(Address) 1338 N. Calhoun St

15 Filed ..... 1923 ..... Registrar

Robert P. Lattimore
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 8 1923 to Feby 13 1923, that I last saw him alive on Feby 13 1923, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D. V. Knowles, M. D.

2/15 1923 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charlottesville Va — DATE OF BURIAL: 2-17 1923

20 UNDERTAKER: Jas A. Tradin — ADDRESS 1424 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 17 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72582

D72582

CERTIFICATE OF DEATH.

31

25

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospi ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Dapshie

(a) RESIDENCE NO. 809 Curtis ave., Curtis Bay ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 Yrs mos. ds. How long in U. S., If of foreign birth? Unkn yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Michael Dapshie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Ellen ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Hospital Records (Address) M.T.H.

15 Robert P. Griffin, 19 Burial Permit Clerk. Registrar

2 17 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1923, to Feb. 16, 1923, that I last saw him alive on Feb. 16, 1923, and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Frances J. Dapshie M. D.

2-16 1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A.A.

DATE OF BURIAL 19

20 UNDERTAKER: John Grebliauckas J.G.

ADDRESS 425 S. Paca

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72583

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72583

CERTIFICATE OF DEATH.

11-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 211 N. Caroline St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Cassidy

(Residence in Baltimore: No. 211 N. Caroline St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, Divorced. (Write the word.)
Male	White	~~Married~~

6-DATE OF BIRTH. March (Month) 24 (Day) 1880 (Year)

7-AGE. 42 yrs. 10 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Huckster
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto.Md.

PARENTS.

10-NAME OF FATHER, Wm. Cassidy

11-BIRTHPLACE OF FATHER, (State or Country). Balto.Md.

12-MAIDEN NAME OF MOTHER, Mary V. Bowen

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Cassidy

(Address) 211 N. Caroline

15-

Filed 192.....

Registrar.

FEB 17 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 15/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Haemoptysis

Bronchopneumonia- Probably

Inflenza (Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. H. H. Pallen M. D. (Coroner.)

2-16 1923 (Address) 408 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oak Lawn DATE OF BURIAL. 2/18 1923

20-UNDERTAKER. Philip Henry Oleam ADDRESS 2016

IMPORTANT: In filling out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72584

CERTIFICATE OF DEATH.

100-00 V D72584

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 S. Duncan ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Freeburg

(a) RESIDENCE NO. 27 S. Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Sept 6 19—

7 AGE: Years 6 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Wilbert Freeburg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Edna Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Margaret Moore

(Address): 122 N. Dallas St.

15 Filed FEB 17 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1923, to Feb. 15, 1923.

that I last saw h— alive on Feb. 15, 1923,

and that death occurred, on the date stated above, at 3 41 m.

The CAUSE OF DEATH* was as follows:

"Capillary bronchitis"

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Acute bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno B Robinson M. D.

2/15/23 (Address) 1520 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Feb 17 1923

20 UNDERTAKER: Mrs R. A. Elliott — ADDRESS: 1756 Ashland Ave

Burial Permit Issued

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72585

CERTIFICATE OF DEATH.

44 D72585

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Little Sisters of the Poor, ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Cole.

(a) RESIDENCE. NO. Preston & Valley Sts. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1833.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Thomas Cole

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Cates.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Sister Florence.
(Address) Little Sisters of the Poor.

15 2/17 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-16 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/11 1923 to 2-16 1923, that I last saw h alive on 2-15 1923, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr Bernard Cohn, M. D.
2/16 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Feb 17 — 1923

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Greenmount

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B 1

D72586

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182 D72586

REGISTERED NO. C.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Foot of Bond St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gustave D Johansen

(Residence in Baltimore: No. Unknown St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Unknown

6-DATE OF BIRTH. Unknown ....., 1..... (Month) (Day) (Year)

7-AGE. About 59 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)..... 087

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15- Filed ..... 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

FEB 17 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Feb 6th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by me and ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

Feb 14th 1923 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

Back Fld

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL, ..., 19....
20-UNDERTAKER	ADDRESS FEB 17 1923

JOHNS HOPKINS HOSPITAL
Commissioner of Health.
THE MORGUE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72587

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D72587

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Park Heights & 7 Mile Lane ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John V. Hoffman

(Residence in Baltimore: No. Park Heights & 7 Mile Lane St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, May 9, 1845
(Month) (Day) (Year)

7-AGE, 78 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Ephriano Hoffman

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Caroline A Horn

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise C. Hoffman

(Address) Park Heights & 7 Mile Lane

15- Filed FEB 17 1923, 19..

Robert F. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) and that said deceased came to death on the date stated above.

The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John V. Hoffman M. D.
(Coroner.)

Feb 17 1923 (Address) 2222 Reland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, Feb 17, 1923

20-UNDERTAKER J. C. Mitchell — ADDRESS 1201 W Fayette

GE should be stated EXACTLY. PHYSICIANS should fill every item of information should be carefully supplied. AGE should be stated properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. CAUSE OF DEATH in plain terms, so that it may be

Spec.—1-10-21—M&T—1500 Bks.

Sobus

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72588

CERTIFICATE OF DEATH.

31 D72588

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 S. Ann St V WARD)

2-FULL NAME Mary Sobus

(a) RESIDENCE NO. 203 S. Ann St WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. 8 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Sobus

6 DATE OF BIRTH (month, day, and year) June 6 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	30	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wojciech Kipa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Maggie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant W. F. Sadowski

(Address) 908 S. Ann St

15 Filed 1923 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10 1922 to Feb 14 1923

that I last saw h alive on Feb 14 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs mos 8 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) John H. Owen, M. D.

Feb 16 1923 (Address) 35 N Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem.

DATE OF BURIAL Feb 19 1923

20 UNDERTAKER W. F. Sadowski

ADDRESS 908 S Ann St

17 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72589

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72589

CERTIFICATE OF DEATH.

159-09

1-PLACE OF DEATH

City of BALTIMORE: (No. 703 Eaton av St. 20 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Betty J. Nichols

(Residence in Baltimore: No. 703 Eaton av St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Single

6-DATE OF BIRTH. Feb (Month) 15 (Day) 1823 (Year)

7-AGE. .....yrs. .....mos. 1 ds. If LESS than 1 day, 12 hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto city

PARENTS.

10-NAME OF FATHER. Wm Nichols

11-BIRTHPLACE OF FATHER, (State or Country). Balto md

12-MAIDEN NAME OF MOTHER. Mary Edwards

13-BIRTHPLACE OF MOTHER, (State or Country). Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Nichols

(Address) 703 Eaton St

15-

Filed 1 7 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 16 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to then death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion Disappearance

(Duration) .....yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Contusion

(Duration) .....yrs. .....mos. .....ds.

(Signed) Jas M Benton M. D. (Coroner.)

Feb 17 1923 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cem:	Feb: 17: 1923
20-UNDERTAKER. C. W. Dill	ADDRESS 3109 Fredk. Ave:

1

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72590

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72590

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 22 Redding Court. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Jackson. (C). 30 ----------.

(Residence in Baltimore: No. 22 Redding Court. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female.	Colored.	Widow.

6-DATE OF BIRTH. Do not know. (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
55 yrs. -- mos. -- ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None. f-0
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Virginia.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER. (State or Country). Do not know.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER. (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Jackson. (C) (daughter).

(Address) 1012 Leadenhall St.

15- Filed 1923

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 15, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

Feb. 16, 1923. (Address) 1011 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Dr. Hill	2/17/23
20-UNDERTAKER.	ADDRESS
K L Parham	22 n McC...

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72591

CERTIFICATE OF DEATH.

11-00 D72591

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2½ St. 2nd Cor. Grafton ST., 25 WARD)

2-FULL NAME Geo. Wesley Miller

(a) RESIDENCE No. 2½ St. 2nd Cor. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Dec. 31/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Infant

(b) General nature of industry, business, or establishment in which employed (or employer) ..... do

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Ashby Miller

11 BIRTHPLACE OF FATHER (city or town) Caroline Co.
(State or country) Va.

12 MAIDEN NAME OF MOTHER Lillie Amanda Pitt

13 BIRTHPLACE OF MOTHER (city or town) Henderson
(State or country) N.C.

14 Informant Ashby Miller
(Address) 1 Fairfield Md.

15 Filed ..... 19 .....
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1923, to Feb. 7, 1923, that I last saw h.. alive on Feb. 15, 1923, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 3 hours ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jas. B. Brown, M. D.

2/7, 1923 (Address) 211 Church Sq, Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn C.

DATE OF BURIAL Feb. 19 1923

20 UNDERTAKER J. L. Brown & Son

ADDRESS 1084 W. Montgomery St.

17 1923

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72592

CERTIFICATE OF DEATH.

100-001 D72592

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2138 N Mount ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Gough

(a) RESIDENCE. No. 2138 N. Mount ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apl- 1921

7 AGE: Years: 1 Months: 10 Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): T Baco

PARENTS

10 NAME OF FATHER: Wm Gough

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ellen Rand

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wm Gough

(Address): 2138 N Mount

15 Filed FEB 17 1923 Robert F. Maddox Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1923, to Feb 16, 1923, that I last saw h alive on Feb 15, 1923, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

1 Bronchial Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Norwood, M. D.

Feb 16, 1923 (Address) 1398 Longwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Ct — DATE OF BURIAL: Feb. 18- 1923

20 UNDERTAKER: J. W. Bloomfield Son — ADDRESS: 1010 Monty

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72593

CERTIFICATE OF DEATH.

74-00 D72593

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 730 N. Carolina ST.; 10 WARD)

2-FULL NAME Mary Etta Wallace

(a) RESIDENCE. NO. 730 N. Caroline ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): James A. Wallace

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 60; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Edward Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Lillian Venable

(Address) 730 N. Carolina St

15 Filed . 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1923, to Feb 10, 1923, that I last saw h[illegible] alive on " " 1923, and that death occurred, on the date stated above, at 4.30p m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism

Contributory

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin Fisher, M. D.

2/19 1923 (Address) 730 N. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury, Cem.	2/19/ 1923
20 UNDERTAKER	ADDRESS
Jas. H. Skinner	1625 E. Fred. St

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72594

CERTIFICATE OF DEATH.

100-001

D72594

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3402 Alto Ave ST. 15 WARD)

2-FULL NAME John J. Pfaff.

(a) RESIDENCE NO. 3402 Alto Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa F. Pfaff.

6 DATE OF BIRTH (month, day, and year) March 13, 85.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
37		10	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Treasurer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Commercial Credit Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Pfaff.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Snyder.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. John Pfaff.

(Address) 3402 Alto Ave.

15 Robert P. Harrison, Registrar

FEB 7 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-16- 1923.

17 I HEREBY CERTIFY, That I attended deceased from 2-12- 1923, to 2-16- 1923.

that I last saw him alive on 2-16- 1923.

and that death occurred, on the date stated above, at 2.50 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Merrill Sorell, M. D.

. 19 (Address) 3705 Liberty Hgts Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL 2/19/23

20 UNDERTAKER Chas. F. Evans & Son

ADDRESS 1184 W. Mt. Royal Ave

Notice should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72595

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72595

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Md. Gen. Hosp St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Robert Button

(Residence in ~~Baltimore~~: No. Owings Mills, Md. St.; yrs.,.....mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Unknown ....., 1..... (Month) (Day) (Year)

7-AGE. 55 yrs. mos. ds. If LESS than 1 day. ....hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward H Underhold

(Address) 150 N Gay St

15- Filed Feb 17 1923 Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 15, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of femur left (accidental) (Slipped on ice)

(Duration) .....yrs. .....mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) .....yrs. .....mos. 2 ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Feb. 16 1923 (Address) 2 Mt Lemmon Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos. 10 ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Owings Mills, Md.

Former or usual residence. Same as above.

19-PLACE OF BURIAL OR REMOVAL. London Park Cem. DATE OF BURIAL, Feb 17, 1923.

20-UNDERTAKER. Harry H. Hughes ADDRESS 1531 W Lombard

If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72596 D72596

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4007 Falls Road ST. 13 WARD)

2-FULL NAME John T. Graham

(a) RESIDENCE. NO. 4007 Falls Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed or divorced HUSBAND of (or) ~~WIFE~~ of Elizabeth T. Graham

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1833

7 AGE: Years 89 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elizabeth Slater
(Address) 4007 Falls Road

15 Filed FEB 17 1923 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb, 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1923, to Feb 15, 1923, that I last saw him alive on Feb 15, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G. Wm. Hoff M. D.

2/15 1923 Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friend's Country Harford Rd

DATE OF BURIAL: 2/19 1923

20 UNDERTAKER: W.M. Cook

ADDRESS: 502 W. Fay

(Burial Permit Clerk.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72597

CERTIFICATE OF DEATH.

91-00 D72597

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 N Pat-Park Ave ST., 8 WARD)

2-FULL NAME Sarilla Phillipina Strobel

(a) RESIDENCE NO. 1403 N Pat-Park Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard S Strobel

6 DATE OF BIRTH (month, day, and year): May 28 1838

7 AGE: Years 84 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Mc Kinnie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mc Kinnie

12 MAIDEN NAME OF MOTHER: Mc Kinnie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mc Kinnie

14 Informant: Annie M. Harkins

(Address): 1403 N Pat-Park Ave

15 Robert P. Morrison, .19 Registrar

8 17 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1923, to Feb 16, 1923

that I last saw h[illegible] alive on Feb 16, 1923

and that death occurred, on the date stated above, at 7-30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Senelity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B F Herzog (not) M. D.

2/17, 1923 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkville Mt. Carmel Cem. | DATE OF BURIAL: Feb 18 1923

20 UNDERTAKER: Wm Cook | ADDRESS: 512 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72598

100-00 b72598

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 So. Paca ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Sandure

(a) RESIDENCE NO. 602 So Paca ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Sandure

6 DATE OF BIRTH (month, day, and year): Mch 15 [illegible]

7 AGE: Years 77 | Months 11 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Thomas Sandure

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Sarah [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mary Sandure (Address) 602 So Paca

15 Filed 1923 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 1923 to Feb 15 1923

that I last saw him alive on Feb 15 1923

and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Rheumatism Chronic

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) L Bontekoe, M. D.

19 23 (Address) 1901 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Sandtown — DATE OF BURIAL: Feb 17 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 932 Dolphin

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

3 17 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72599

CERTIFICATE OF DEATH.

11-001 D72599

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 N. Washington St., WARD) 8

2-FULL NAME Raymond B. Johnson

(a) RESIDENCE NO. 1034 N. Washington St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 22-1913

7 AGE Years 9 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Thos Sherman 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Walter R. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mollie Ramach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mollie Johnson

(Address) 1034 N. Washington

15 Filed , 19 Robert F. Hartsock Registrar

7 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) February 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 2nd, 1923, to Feb 16th, 1923, that I last saw h— alive on Feb 16th, 1923, and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Hennig Boyd M.D. M. D.

2/16/23 (Address) 1 E 35th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 2/19 1923

20 UNDERTAKER Wm Cook

ADDRESS 5022 Park

INSTRUCTIONS: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72600 31 D72600

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2044 E. Hoffman ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Steinman

(Residence in Baltimore: No. 2044 E. Hoffman, St.; 24 yrs., 5 mos. 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. August 30th (Month) (Day), 1898 (Year)

7-AGE. 24 yrs. 5 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frederick J. Steinman

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Lillian Reed

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A. Armstrong

(Address) 2044 E. Hoffman St.

15- 1923 Robert P. Harrison, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 15 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 16 1922, to Feb 16 1923, that I saw h... alive on Feb 14 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary Tuberculosis

(Duration) ....yrs. 8 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John A. Carey M. D.

191... (Address) 1609 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Feb. 19, 1923

20-UNDERTAKER Henry Lutz

ADDRESS 1203 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1

Spec.—8-24-14—M. & T.—2000 Bks.

72696 D72601

HEALTH DEPARTMENT—CITY OF BALTIMORE

72601 129 72601 D72601

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 Mc Elderry ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca Robinson

(Residence in Baltimore: No. 1508 Mc Elderry St.; 45 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, unknown (Month), 1 (Day), ... (Year)

7-AGE, approx 60 yrs ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At home
(b) General nature of industry, business, or establishment in which employed (or employer). D.

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William T. Robinson (Nephew)

(Address) 1446 Belvidere st

15- Filed FEB 18 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 15 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 8 1922, to Feb 15 1923, that I saw h[er] alive on Feb 14 1923, and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous
Nephritis
(Duration) yrs. 3 mos. ..., ...ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency
(Duration) yrs. 3 mos. ..., ...ds.

(Signed) R F Corning M. D.
2-17-23, 191.2 (Address) 1429 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Natal Rest — DATE OF BURIAL. Feb 19 ..., 192[3]

20-UNDERTAKER Theodore L Kitt — ADDRESS N 3 Bellevue

IMPORTANT.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

16412 D72602 72602 D72602 72602 D72602

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 5 WARD)

2-FULL NAME Flora Elliott

(a) RESIDENCE NO. 1036 Hillen St ST., ... WARD North Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 months ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Wesley Elliott

6 DATE OF BIRTH (month, day, and year): March 1896

7 AGE: Years 26 Months 11 Days ..... If LESS than 1 day, ...hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER Sam McAllister

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER Carrie E. Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 16 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 22, 1922, to Feb 16, 1923, that I last saw her alive on Feb 16, 1923, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Multiple neuritis

(duration) ..... yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) Edward R Bugg M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland Co, N C

DATE OF BURIAL: Feb 17, 1923

20 UNDERTAKER: Mrs Robert A Elliott

ADDRESS: 1735 Fayetteville St NC

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72603 D72603

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pennington Ave. 42d. 161-501

CITY OF BALTIMORE: (No. 1st house below entrance to U.S.C. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Richard Short

(a) RESIDENCE NO. Same as above ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 13 23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER William Richard Short

11 BIRTHPLACE OF FATHER (city or town) Pennsylvania

(State or country)

12 MAIDEN NAME OF MOTHER Mary Gertrude Cheek

13 BIRTHPLACE OF MOTHER (city or town) Marley

(State or country) Anne Arundel Co. Md.

14 Informant Mrs. Gertrude Short

(Address) Penn. Ave. - Ext.

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13th, 1923, to Feb 17, 1923, that I last saw h alive on Feb. 17, 1923, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Inanition - premature birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. B. Davis M. D.

2/17, 1923 (Address) 211 Church St, Centre Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charley Cheek Cemetery

DATE OF BURIAL Feb 19 1923

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72604

CERTIFICATE OF DEATH.

31

D72604

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1832 Linden ave ST., 14 WARD)

2-FULL NAME Ellis Colin

(a) RESIDENCE NO. 1832 Linden ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	m	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city Md

PARENTS

10 NAME OF FATHER Wolf Colin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Raechel Loffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Balto st

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22 to Feb 17 1923, that I last saw h[illegible] alive on Feb 16 1923, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Several yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Laboratory

(Signed) Morton Strauss M. D.

, 19 (Address) 712 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rash Rel Cem DATE OF BURIAL 2/18 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72605 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D72605

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2304 E. Balto ST., 6 WARD)

2-FULL NAME Rosie Silverstein

(a) RESIDENCE NO. 2304 E. Baltimore ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred hrs. mos. ds. How long in U. S., if of foreign birth? hrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Samuel Silverstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Smarka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1431 E. Baltimore

15 Filed FEB 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1922, to Feb 17, 1923, that I last saw her alive on Feb 15, 1923, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Pemphigus

(duration) — yrs. 8 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) T. Caspar Gilchrist, M. D.

, 19 (Address) Professional Bldg 330 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lehren Herring Rm

DATE OF BURIAL 2/18 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1431 E. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10 21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72606

CERTIFICATE OF DEATH.

117 D72606

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Monument St Hebrew Hospital ST., 5 WARD)

2-FULL NAME Mrs. Bessie Sirken

(a) RESIDENCE NO. 225 N. Front St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state AGE should be stated EXACTLY.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abraham Sirken

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE: Years 60 | Months — | Days — | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Morris Sirken

(Address): No 24 E Baltimore St

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1922 to Feb 17, 1923, that I last saw h er alive on Feb 17, 1923, and that death occurred, on the date stated above, at 12 Noon.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency with general vasomotor collapse

(duration) yrs. mos 61 ds.

CONTRIBUTORY (Secondary) Acute appendicitis + operation (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Dec 21, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis Sachs, M. D.

, 1923 (Address) 1 E Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 2/18 1923

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

(See affadavit and Letter attached)

D72607

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002 D72607

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

CITY OF BALTIMORE: (No.) ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sol S Shapiro

(a) RESIDENCE NO. 625 Eight St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Shapiro

6 DATE OF BIRTH (month, day, and year) April 4 1869 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54	53?	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ellis Shapiro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Goldie Greifeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13 . 1923 . to Feb 16 . 1923 .

that I last saw him alive on Feb 16 - 1923 ,

and that death occurred, on the date stated above, at 6.50 a m.

The CAUSE OF DEATH* was as follows:

(1) Necrosis Colon and Ascending Colon (2) Mesenteric Thrombosis?)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxaemia. Intestinal Obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of Feb. 14 '23

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) D L Brannan . M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrer Mach Road — DATE OF BURIAL 2/18 1923

20 UNDERTAKER Jack Lewis 1439 E. Balto St — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THE JOHNS HOPKINS HOSPITAL
Baltimore Md.

Mar 2, 1923.

Dr H C. Jones.
Health Com. Balto City.
Balto Md.

Dear Dr Jones:-

This is to certify that age of Sol Shavitz as given on death certificate was 57 years. If there was a mistake as to his age I was not aware of same. He was very ill when seen and such non essential details were not investigated.

Yours truly
D Brannan.

STATE OF MARYLAND, CITY OF BALTIMORE, to wit:

I HEREBY CERTIFY, that on this 26th day of February, in the year one thousand nine hundred and twenty-three before me, the subscriber, a Notary Public of the State of Maryland, in and for the City of Baltimore aforesaid, personally appeared MOSES SHAVITZ, and made oath in due form of law that he is brother of one SOLOMON SHAVITZ, late of Baltimore City deceased, and that the said SOLOMON SHAVITZ departed his life on February 16th, 1923; that at the time his age was given to Johns Hopkins Hospital authorities and to the undertaker as fifty-seven years, but his correct age is fifty-four years; that the date of his birth is April 4th, 1869, thereby making his age fifty-four years next April.

Moses Shavitz
AFFIANT.

AS WITNESS my hand and Notarial Seal

Elizabeth Heintzeman
Notary Public.

WHEN REPLYING TO THIS COMMUNICATION, BE SURE TO GIVE CORRECT POLICY NUMBER

Spec.—1-10-21—M&T—1500 Bks.

D72608

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D72608

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2118 Brookfield Ave ST., 13 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer Bloom

(a) RESIDENCE NO. 2118 Brookfield ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 36 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca Bloom

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 46 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Alexander Bloom

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rena

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Balto

15 FEB 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1923, to Feb 16, 1923,

that I last saw her alive on Feb 16, 1923,

and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Grippe & Lobar pneumonia

(duration) ... yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Pleurisy Cardiac failure (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? /

(Signed) Chas F Bloch, M. D.

2/16/1923 (Address) 202 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew Cem

DATE OF BURIAL: 2/18 1923

20 UNDERTAKER: Jack Lewis 1439 E Balto

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D72609

HEALTH DEPARTMENT—CITY OF BALTIMORE

43 D72609

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1735 N. Washington St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John J. Connolly

(a) Residence No. 1735 N. Washington St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) January 10, 1853

7-AGE. 70 yrs. 1 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). Odd jobs

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John J Connolly

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Ellanora Kennedy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Elizabeth Pledge

(Address) 1822 N. North

15- FEB 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 16 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 19 22 to Feb 16 19 23

that I last saw h[illegible] alive on Feb 14 19 23

and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis Coronary sclerosis

Duration yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Feb 19 23 (Address) 10 E Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL. Feb [illegible] 1923

20-UNDERTAKER. Wendell Oppel & Son — ADDRESS 378 Penn

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72610 — 129 — D72610

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2439 Woodbrook Ave ST. 15 WARD)

2-FULL NAME Louis A. Hirshberg

(a) RESIDENCE NO. 2439 Woodbrook Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Hirshberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bath-Md (State or country)

PARENTS

10 NAME OF FATHER—Nathan Hirshberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Henrietta Schonberger

13 BIRTHPLACE OF MOTHER (city or town) Bavaria (State or country)

14 Informant Mrs Alice Polack

(Address) 2439 Woodbrook Ave

15 FEB 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 19 23

17 I HEREBY CERTIFY, That I attended deceased from Feb 1st, 19 23, to Feb 16, 19 23,

that I last saw him alive on Feb 16, 19 23,

and that death occurred, on the date stated above, at 10 0 m.

The CAUSE OF DEATH* was as follows:

Chr Interstitial Nephritis

Dont Know (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. Glozk, M. D.

19 (Address) 1737 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cemetery	Feb 18 19 23
20 UNDERTAKER	ADDRESS
J. Abrams & Sons	1 Lexington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72611

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72611

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2128 Harford Ave ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rebecca Reid

(a) RESIDENCE NO. 2128 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. NOTE—Should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Samuel Reid

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 89 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr. John A. Reid

(Address) 2128 Harford Ave

Filed FEB 18 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 17 1923

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1923, to February 17, 1923, that I last saw her alive on February 16, 1923, and that death occurred, on the date stated above, at One a m.

The CAUSE OF DEATH* was as follows:

old age

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Heart disease

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. Young Westbrook, M. D.

2-17-1923 (Address) 1611 Gorsuch ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: February 19 1923

20 UNDERTAKER: Henry Hoerle Sons — ADDRESS: 1301 E Eager st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72612

CERTIFICATE OF DEATH.

101-001 D72612

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 859 N. 36th St. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millard M. Burgee Jr.

(a) RESIDENCE NO. 859 N. 36th St ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jan. 6-1908

7 AGE: Years 15 Months 1 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Millard M. Burgee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth M. Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Maryland

14 Informant (Address): Millard M. Burgee 859 N. 36th St.

15 Filed FEB 18 1923 ROBERT R. KRAMER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 14 1923 to Feb 16 1923, that I last saw him alive on Feb 16-23, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Irvon Draewood M. D.

2-19-1923 (Address) 846 W 36th St —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: Feb 19 1923

20 UNDERTAKER: Horace H. Burgee

ADDRESS: 1631 Hall St

Spec. 1-19-21 M&T 1500 Blks.

D72613 HEALTH DEPARTMENT—CITY OF BALTIMORE D72613

CERTIFICATE OF DEATH. 11-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., N WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Gray

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Gray

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	47	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Municipal Hospital Records.

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from February 6, 1922, to February 14, 1923, that I last saw her alive on February 13, 1923, and that death occurred, on the date stated above, at 1:00 A.M.

The CAUSE OF DEATH* was as follows:

1. Influenza

2.

3.

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

2-15 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 BLACK OF BURIAL, CREMATION OR REMOVAL M. Auburn DATE OF BURIAL 2-16 1923

20 UNDERTAKER Sam'l H. Chase Inc ADDRESS 1100 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D72614

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72614

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 Robert ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Waters

(a) RESIDENCE NO. 422 Robert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30 /22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	17	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Peter Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Bessie Waters (Address) 422 Robert St

15 FEB 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1923, to Feb 17, 1923.

that I last saw h-e alive on Feb 16, 1923

and that death occurred, on the date stated above, at 2-05 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E W Chamney, M. D.

2/17, 1923 (Address) 928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Feb 18 1923

20 UNDERTAKER Wm H. Chase Son — ADDRESS 1405 Madison

MEDICAL ATTENDANCE GIVEN BY PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stoec—6-8-19—H. P. Co.—1000 Blks.

D72615 HEALTH DEPARTMENT—CITY OF BALTIMORE D72615

CERTIFICATE OF DEATH. 101-601

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 413 N. Carey St. (St.) 18 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Annie M. Baudelman

(a) RESIDENCE. No. 413 N. Carey St St., Ward. Hanover Pa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apl 15/1883

7 AGE: Years 39 years. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover. Pa

PARENTS

10 NAME OF FATHER J. J. Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary A. Carpenter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) John J. Schmidt Hanover Pa.

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17—1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1923, to Feb 17—, 1923, that I last saw h alive on Feb 17—, 1923, and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bright Compensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Consultation

(Signed) Jos Claudius Bladel, M. D.

(Address) 1436 Bray.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hanover Pa.

DATE OF BURIAL: Feb 18 1923

20 UNDERTAKER: J. B. Mitchell

ADDRESS: 120 W Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D72616

CERTIFICATE OF DEATH

129

D72616

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. 810 W. Northern ave ST. 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Emma May Smith

(Residence in Baltimore: No. 810 W North Ave St. ... yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single.

6 DATE OF BIRTH: Nov 20 / (Month) (Day), 1870 (Year)

7 AGE: 52 yrs. ... mos. ... ds. — If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto

PARENTS

10 NAME OF FATHER: Alfred J. Smith

11 BIRTHPLACE OF FATHER (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary E. Akers.

13 BIRTHPLACE OF MOTHER (State or country): Balto Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Eva Hodson

(Address) 810 W. North ave.

15 Filed FEB 19 1923 191

ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: February 16 (Month) (Day), 1923 (Year).

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1918, to Feb. 16 1923 that I saw her alive on Feb 16, 1923, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart.

8 hours
(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) Chronic Interstitial Nephritis
about 5
(Duration) ... yrs. ... mos. ... ds.

(Signed) Carroll Lockard M. D.

Feb 17, 1923 (Address) 413 Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. — In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Forest Lodge. — DATE OF BURIAL: Feb 19/22, 1923

20 UNDERTAKER: J. E. Mitchell — ADDRESS: North Capitol

Spec. 6-2-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72617

14 14-001 D72617

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2246. Madison Ave ST. (WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Ebert Riefle

(a) RESIDENCE. No. 2246. Madison Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (Write the word): Married

5a If married, widowed, or divorced — HUSBAND (or ~~WIFE~~) of: George F. Riefle.

6 DATE OF BIRTH (month, day, and year): June 9 1850

7 AGE — Years: 72 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Henry Curtain

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Sarah Ebert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Prussia.

14 Informant: George F. Riefle (Address) 2246 Madison Ave

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Registrar — Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 20th, 1923, to Feb. 16th, 1923, that I last saw h~~er~~ alive on Feb. 16th, 1923, and that death occurred, on the date stated above, at 6. A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel Weinberg, M. D.

, 19 (Address) 2302 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: Feb 19. 1923

20 UNDERTAKER: John O. Mitchell — ADDRESS: 1201 W Fayette St

Burial. 2302 Madison Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D72618

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100—10/D72618

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hosp ST., 2 WARD)

2-FULL NAME Dora Morganstein

(a) RESIDENCE NO. 227 S Eagle St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 7 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hans Rosenfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mollie Richter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Nathan Morganstein (Address) 227 S Eagle St

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 17 1923

17

I HEREBY CERTIFY, That I attended deceased from January 31, 1923, to February 17, 1923.

that I last saw her alive on February 17, 1923,

and that death occurred, on the date stated above, at 3 2 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. ... mos. 1. ds.

CONTRIBUTORY (Secondary) Catarrhal Jaundice

(duration) yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) John A. O'Connor, M. D.

2/17 1923 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and t2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 2/18 1923

20 UNDERTAKER D. Levinson

ADDRESS 1167 E Balto St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72619

CERTIFICATE OF DEATH.

90 D72619

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S. Clinton St. ST., No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Kuhn.

(a) RESIDENCE NO. 319 S. Clinton St. ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39. yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Kuhn.

6 DATE OF BIRTH (month, day, and year) May 27—1839.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Conrad Kuhn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Conrad Kuhn. (Address) 319 S. Clinton.

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb 16 , 1923 , to Feb 16 , 1923.

that I last saw her alive on Feb 16 , 1923 ,

and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tatlow M. D.

2/17, 1923 (Address) 315 S. Highlandtown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Josephs Cem.

DATE OF BURIAL Feb 19 1923

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 S. Wolfe St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72620

CERTIFICATE OF DEATH.

90 D72620

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3473 Foster Ave ST., 26 WARD)

2-FULL NAME Katherine Gebhardt.

(a) RESIDENCE NO. 3473 Foster Ave. ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Gebhardt.

6 DATE OF BIRTH (month, day, and year) Nov. 25-1825.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	97	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Zaier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Barbara Gebhardt.

(Address) 3473 Foster Ave.

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 15, 1923.

that I last saw h alive on Feb 15, 1923

and that death occurred, on the date stated above, at 11.05 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis 6 mos

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W. L Burke M. D.

, 19 (Address) 3042 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Feb. 19 1923.
20 UNDERTAKER Tilly & Zaier.	ADDRESS 403 S. Wolfe St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D72621 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72621

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St. 4 WARD)

2-FULL NAME Howard Wilson

(a) RESIDENCE NO. 306 N. Green st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 2 ? 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jas. M. Wilson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Shaffer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address) M.T.H.

15 Filed FEB 18 1923 ROBERT F. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1923, to Feb. 17, 1923,

that I last saw him alive on Feb. 17, 1923,

and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 2 ? mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? .....

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Hamer L. Donaghue M. D.

2-17-23, 19 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 2/19 1923

20 UNDERTAKER Wm Cook

ADDRESS 504 E. Nort

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72622

CERTIFICATE OF DEATH.

159-002 D72622

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Archer ST., 21 WARD)

2-FULL NAME Geo Melvin Barker

(a) RESIDENCE NO. 518 Archer ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb - 11 23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo M. Barker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Cecelia Reinhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Geo M. Barker
(Address) 518 Archer St

15 Filed FEB 18 1923 ROBERT A. KRAUTER, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1923, to Feb 17, 1923, that I last saw him alive on Feb 16, 1923, and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Impetigo Contagiosa

Facilitus of Foramen Ovale

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Brain, M. D.

, 19 (Address) 22 Mark Bower

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 2/19 1923

20 UNDERTAKER Wm Cook — ADDRESS 508 E Nath

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72623

REGISTERED NO.

D72623

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 362 Maryland ST., Westport 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Quinn

(a) RESIDENCE NO. 363 Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Quinn

6 DATE OF BIRTH (month, day, and year) Dec. 28. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER John Williamson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Gertrude Bradyson

(Address) 362 Maryland

15 Filed FEB 18 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1923, to Feb. 17, 1923, that I last saw her alive on Feb. 17, 1923, and that death occurred, on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm. J. Peabody, M. D.

2/17. 1923 (Address) 638 Fallsway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery DATE OF BURIAL 2/21 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E North

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72624

CERTIFICATE OF DEATH.

14-001 D72624

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2178 Washington ST., W WARD)

2-FULL NAME Laura V. Fuller

(a) RESIDENCE NO. 2178 S. Washington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H Fuller

6 DATE OF BIRTH (month, day, and year) July 9 1857

7 AGE Years 75 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co (State or country) Md

PARENTS

10 NAME OF FATHER William Sewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Md

12 MAIDEN NAME OF MOTHER Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Brune (Address) 2175 Etch

15 Filed FEB 18 1923, 19 ROBERT S. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 3rd, 1923, to Feby 17th, 1923, that I last saw h alive on Feby 15th, 1923 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Robert S. Kurtz M. D.

2/17, 1923 (Address) 3126 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL 2/19, 1923

20 UNDERTAKER McCorkle Fun'l Dir. ADDRESS 5021 W. Lafayette Ave

INSTRUCTIONS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

D72625

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72625

CERTIFICATE OF DEATH.

46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hosp ST., 15 WARD)

2-FULL NAME Ida Mclehean

(a) RESIDENCE NO. 2943 clayton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-30-1855

7 AGE: Years 67; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jacob Eppler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Caroline Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant Jacob Eppler

(Address) 2202 Walbrook Ave

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 16 1923

17

I HEREBY CERTIFY, That I attended deceased from December 6 1922 to February 16 1923.

that I last saw her alive on February 16 1923,

and that death occurred, on the date stated above, at 10 [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) John A Common M. D.

19 (Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County

DATE OF BURIAL 2/19 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E North

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72626

D72626

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 W Saratoga ST., 4 WARD)

2-FULL NAME Corine Shuford

(a) RESIDENCE NO. 732 W. Saratoga ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Shuford

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE Years 33 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

137

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Elijah Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hattie Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Albert Shuford 732 Saratoga St.

15 Filed FEB 18 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 14th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 9th, 1923, to Feby 14th, 1923, that I last saw her alive on Feby 14th, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonic Phthisis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Howells, M. D.

2/18/ 1923 (Address) 1191 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 2/18 1923

20 UNDERTAKER Samuel J Handley ADDRESS Mt Auburn

Attention should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1616 89
D72627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72627

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " ST., 14 WARD)

2-FULL NAME Mabel Carter.

(a) RESIDENCE NO. 1903 Mc Culloch St City. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~Husband of~~ (or) Wife of: John Carter (Father)

6 DATE OF BIRTH (month, day, and year): May 17, 1920

7 AGE: Years 2; Months 9; Days 1; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): (-)

(c) Name of employer: (-)

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Carter,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mabel Greene

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): JOHNS HOPKINS HOSPITAL. ~~Baltimore~~

15 Filed FEB 18 1923 ROBERT R. KRAUSE Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 18, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1923, to Feb. 18, 1923, that I last saw her alive on Feb. 15, 1923, and that death occurred, on the date stated above, at 9:45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): Primary

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. A. Weech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem

DATE OF BURIAL 2/20/23

20 UNDERTAKER: Samuel Hensley & Bolte

ADDRESS 528

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72628 D72628

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. • 4409 Springdale Ave (WARD) 28

2-FULL NAME. Charles A. Klingebiel Jr

(a) RESIDENCE. No. 4409 Springdale Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 19. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas A. Klingebiel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Jane Cockrill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Charles A. Klingebiel

(Address) 4409 Springdale Ave

15 Filed FEB 18 1923 19 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1923, to Feb. 17, 1923, that I last saw h[illegible] alive on Feb. 17, 1923, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Diag.

(Signed) Herbert A. C. Blake, M. D.

, 19 (Address) 1014 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Feb 19 1923
20 UNDERTAKER	ADDRESS
Mr. & Mrs. J. W. Teufel & Son	501 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Sunley

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72629 — 1-PLACE OF DEATH — 90 — D72629 REGISTERED NO.

CITY OF BALTIMORE: (No.) 608 Harwood Ave (St.) Mrs Barton San Balt Hos (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret. Sunley.

(a) RESIDENCE. No. 608 Harwood Ave St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): 1843

7 AGE: Years 80; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Ann Doyle

(Address) Eastern Ave & Wolfe St.

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 17. 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1923, to Feb. 17, 1923, that I last saw h[illegible] alive on Feb. 17, 1923, and that death occurred, on the date stated above, at 8 [illegible] A. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Haer, M. D.

2 17 1923 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross

DATE OF BURIAL: 2/19 1923

20 UNDERTAKER: Martin Fahey Co

ADDRESS 1217 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72630

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D72630

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 715 N. Durham ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Filip

(a) RESIDENCE. No. 715 N. Durham ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josefina Filip

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 62 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Josef Filip

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): Josefina Filip 715 N. Durham St.

15 Filed: FEB 18 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1923 to Feb 17 1923, that I last saw h alive on Feb 17 1923, and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 9d ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed: William J. Reaver M. D.

Feb. 17 1923 (Address) 84 N. Glenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Feb. 1923

29 UNDERTAKER: Chas. E. Goerbert

ADDRESS: 1906 Eutaw Pl

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72631

CERTIFICATE OF DEATH.

128 D72631

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2440 E Monument ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Koplan

(a) RESIDENCE. No. 2440 E Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Koplan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Fannie Bolek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Joseph Koplan 2440 E Monument St

15 Filed FEB 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1923 to Feb 16 1923

that I last saw him alive on Feb 16 1923

and that death occurred, on the date stated above, at 8.30 p m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis, Hypertension, Uraemic Coma (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Whitridge Williams, M. D.

Feb 22 1923 (Address) 800 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Feb 20 1923

20 UNDERTAKER Lunt Brothers — ADDRESS 1916 Park Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72632

REGISTERED NO.

D72632

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 N. Madeira ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Petrlik

(a) RESIDENCE. NO. 722 N. Madeira ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carolina Petrlik (nee Brown)

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Jacob Petrlik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Carolina Petrlik 722 N. Madeira St

15 Filed FEB 18 1923 19 ROBERT F. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 19 22 to Feb 16 19 23

that I last saw h alive on

and that death occurred, on the date stated above, at 1 Am

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) [illegible] M. D.

19 (Address) 800 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 19 1923

20 UNDERTAKER Frank Drachler ADDRESS 1906 Bank

CAUSE OF DEATH must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21 M&T 1500 Bks.

D72633

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 D72633

1-PLACE OF DEATH 723 St Paul St - 11

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Alfred Livingston

(a) RESIDENCE NO. ..... Jamestown N.Y. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or Divorced, (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Vollie Livingston

6 DATE OF BIRTH (month, day, and year) 1848?

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
74	10?		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Shippensville Pa.

PARENTS

10 NAME OF FATHER John J. Livingston

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) New York

12 MAIDEN NAME OF MOTHER Mary J. Whitehill

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Pa.

14 Informant Miss Clara Livingston
(Address)

15 Filed FEB 18 1923 19 ROBERT N. KRAMER Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1923, to Feb 18, 1923, that I last saw h/ alive on Feb 18, 1923, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder
Metastasis to Liver & Lungs

..... (duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter A Backer M. D.

, 19 (Address) 900 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jamestown N.Y.

DATE OF BURIAL Feb 18 1923

20 UNDERTAKER Henry W Jenkins Sons

ADDRESS McCulloh and Madison

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72634

CERTIFICATE OF DEATH.

101-001 D72634

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 811 W. Lanvale ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Dammann-

(a) RESIDENCE NO. 611 W. Lanvale st ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 11 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single-

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 23 - 1877

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
45	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER S. Francis Dammann

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Maryland

12 MAIDEN NAME OF MOTHER Aileen Cowarding

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Va.

14 Informant Alice D. Rushmore (Address) 811 W. Lanvale St. Balto

15 Filed FEB 18 1923 ROBERT A. KRAUSE Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 14th, 1923, to Feb 17th, 1923, that I last saw her alive on Feb 17th, 1923, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia.

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Washington D.C.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? signs & symptoms

(Signed) Jos. Chatard, M. D.

Feb 18, 1923 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Feb 19th 1923

20 UNDERTAKER Henry Hankins & Sons

ADDRESS Oakland & Mulberry Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

72635 D72635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

72635 90 D72635

REGISTERED No. C.....

1 PLACE OF DEATH 839 W. 34 St.

CITY OF BALTIMORE (No. 839 W. 34 St ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore F.C. Russell

(Residence in Baltimore: No. 839 W. 34th St. St. 46 yrs., mos. ds.)

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 29 (Day), 1852 (Year)

7-AGE, 70 yrs. 7 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Foreman.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Cotton Mills

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Fred. Russell

11-BIRTHPLACE OF FATHER (State or Country). Mass.

12-MAIDEN NAME OF MOTHER Susan Maynard.

13-BIRTHPLACE OF MOTHER (State or Country), Mass.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amanda J. Russell.

(Address) 839 W. 34 St.

15- FEB 19 1923 ROBERT B. KRAUER, Burial Permit Clerk. Registrar.

Filed....., 191.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 16. (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

18- CAUSE OF DEATH* was as follows:

Contusion of Head

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Jno. Morrison M. D.
(Coroner.)

Feb 19 1923 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Lorraine Cemetery	2/19 ....., 1923
20-UNDERTAKER	ADDRESS
Walter Davis	339 Paine

72636

D72636

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

72636 90

D72636

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 939 Forrest ST. 10 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Catherine A. Barry

(Residence in Baltimore: No. 939 Forrest St.; yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED WIDOWED OR DIVORCED (If write the word): Widow

6 DATE OF BIRTH: Feb (Month) 8 (Day), 1856 (Year)

7 AGE: 66 yrs. mos. 8 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework 070
(b) General nature of industry, business, or establishment in which employed (or employer): Belvedere Hotel

9 BIRTHPLACE (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: John Coyle

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Duffy

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jennie Harris

(Address) 739 Forest St

15 FEB 19 1923 Filed, 191 ROBERT R. KRAUTER, Registrar of Burial Permits Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 16 (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1923, to Feb 16 1923, that I saw her alive on Feb 16, 1923, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) James M Benton M. D.

Feb 17, 1923 (Address) 700 E Chase St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Cathedral DATE OF BURIAL: Feb 19 1923

20 UNDERTAKER: E A Wedefeldt ADDRESS: 301 E 22

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72637

CERTIFICATE OF DEATH.

D72637

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 S. Bouldin St. 16 WARD)

2-FULL NAME Lois Virginia Davis.

(a) RESIDENCE. No. 107 S. Bouldin St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Name of disease, or other morbid conditions resulting in death should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laurence Henderson Davis.

6 DATE OF BIRTH (month, day, and year) June 26, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) housework

(c) Name of employer

9 BIRTHPLACE (city or town) Rhodesville
(State or country) Virginia

PARENTS

10 NAME OF FATHER Edgar J. Mann.

11 BIRTHPLACE OF FATHER (city or town) Rhodesville
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Lula Daniel

13 BIRTHPLACE OF MOTHER (city or town) Orange.
(State or country) Virginia.

14 Informant Lawrence Davis.
(Address) 107 S. Bouldin St.

15 Filed FEB 19 1923 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 17 1923.

17 I HEREBY CERTIFY, That I attended deceased from October 31 1922, to February 17, 1923, that I last saw h alive on February 17, 1923, and that death occurred, on the date stated above, at 2.00 P. m.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart (79)
Chronic endocarditis with
acute dilation.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia of
base. (13) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of Feb. 17, '23.

Was there an autopsy? No.

What test confirmed diagnosis? physical signs

(Signed) James Madison Munson M. D.

Feb 19 1923 (Address) 3908 Dunvale Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Onga Va. DATE OF BURIAL 2/19 1923

20 UNDERTAKER John A. Wilson ADDRESS 3000 E. Balto St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72638

CERTIFICATE OF DEATH.

101-001

D72638

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Etting ST., 14 WARD)

2-FULL NAME Erma Carter

(a) RESIDENCE NO. 1808 Etting ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24 1922

7 AGE Years 6 Months 6 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Home (Child)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Matthew H. Carter

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Minnie Frazier

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Minnie Carter

(Address) 1808 Etting St

15 Filed FEB 19 1923 16 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/16 1923

I HEREBY CERTIFY, That I attended deceased from 2/11, 1923, to 2/16, 1923,

that I last saw h— alive on 2/16, 1923,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Influenza

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Brooke Butler, M. D.

2/19, 1923 (Address) 2134 Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

Baltimore Co

DATE OF BURIAL Feb 19 1923

20 UNDERTAKER George T. A. Gibson

ADDRESS 518 N Fremont

IMPORTANT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 111-002

D72639

D72639

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME EMORY BERNARD HINMAN

(a) RESIDENCE NO. University Hospital ST., 4 WARD (Warsaw, N.C.)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs 0 mos. 12 ds. How long in U. S., if of foreign birth? 38 yrs. 11 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Olive Parsons Hinman

6 DATE OF BIRTH (month, day, and year) Feby-27-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber

(c) Name of employer Hinman Manf'g.Co.

9 BIRTHPLACE (city or town) Leemont
(State or country) Virginia

PARENTS

10 NAME OF FATHER Emory D. Hinman

11 BIRTHPLACE OF FATHER (city or town) Leemont
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Middleton

13 BIRTHPLACE OF MOTHER (city or town) Leemont
(State or country) Virginia.

14 Informant Mr. R. T. Hinman (brother)
(Address) Parksley, Va.

15 Filed FEB 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1923, to Feb. 18, 1923, that I last saw him alive on Feb. 18, 1923, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer -
Intestinal adhesions

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes. Date of duodenal ulcer

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms & Oper.

(Signed) Anthony Buchanan M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parksley, Va.

DATE OF BURIAL Feb-19-23

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Supt.)

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72640

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

D72640 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 88½ Main St (Hillsdale) St.) 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Russell Lloyd

(Residence in Baltimore: No. 88½ Main St (Hillsdale) St.; yrs. ..... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Jan 7 1923
(Month) (Day) (Year)

7-AGE. ..... yrs. ..... mos. 21 ds.

If LESS than 1 day, ...hrs. or.... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Hillsdale Md

PARENTS.

10-NAME OF FATHER. David R Lloyd

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. Celia C Truscott

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David R Lloyd

(Address) 88½ Main St.

15-

Filed FEB 19 1923 ROBERT R. KRAMER, Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb. 16 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

Feb. 16 1923 (Address) 2 E Edmondson Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cem	Feb 19 1923
20-UNDERTAKER. Jacob B Cook	ADDRESS 1003 N Eutaw St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72641

CERTIFICATE OF DEATH.

49 ✓ D72641

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2717 N. Calvert St. ST., 12 WARD)

2-FULL NAME Bessie Mathers Staub

(a) RESIDENCE NO. 2717 N. Calvert St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Staub

6 DATE OF BIRTH (month, day, and year) Oct. 17" 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
40	3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Peat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary V. Peterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John T. Staub

(Address) 2717 N. Calvert St.

15 Filed FEB 19 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16" 1923

17 I HEREBY CERTIFY, That I attended deceased from July 15 , 1922 , to Feb 15 , 1923 .

that I last saw her alive on Feb 15 , 1923 ,

and that death occurred, on the date stated above, at 1.30 A.m.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder

(duration) 3 yrs. ? mos ds.

CONTRIBUTORY (Secondary) Cachexia -

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Do not Know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Lawrence R. Wharton, M. D.

2/16 1923 (Address) 2305 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL Feb 19" 1923

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 N. Butts St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72642

CERTIFICATE OF DEATH.

1923 ✓

D72642

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Heitmiller

(a) RESIDENCE NO. 1914 W. Lombard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Sept 17 1844

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
78	5 --	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from February 13, 1923, to February 17, 1923.

that I last saw her alive on February 16, 1923.

and that death occurred, on the date stated above, at 6:58 A.M.

The CAUSE OF DEATH* was as follows:

Fracture of right hip - Extra Capsular.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Examination.

(Signed) Clyde McNeil, M. D.

2-17 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westlegs Cemetery DATE OF BURIAL Feb 19 1923

20 UNDERTAKER H B Wappard ADDRESS 225 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accident
Fracture was
sustained by
falling down stairs

D72643

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002

D72643

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2114 W Pratt St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul Wegerich [Wegerich]

(Residence in Baltimore: No. 2114 W Pratt St.; yrs. 7 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. July (Month) 7th (Day) 1896 (Year)

7-AGE. 27 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): Restaurant

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Joseph Wegerich

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Scott

(Address) 126 N. Paca St.

15- FEB 19 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb (Month) 17 (Day) 1923 (Year)

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Sudden

(Duration) ....yrs. ....mos. 2d. ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ....yrs. ....mos. 4 ds.

(Signed) James M Fenton M. D. (Coroner.)

Feb 19 192) (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral DATE OF BURIAL. Feb 19th 1923

20-UNDERTAKER. F. B. Kuykendall ADDRESS 2336 Eutaw Pl.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72644

CERTIFICATE OF DEATH.

90 D72644

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2021 Harlest ave ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Warno.

(a) RESIDENCE NO. 2021 Harlest ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or Divorced, (write the word)
Male	White	Singer

5a If married, widowed, or divorced HUSBAND of — (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 6. 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Warno.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Hahman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Warno (Address) 2021 Harlest ave

15 Filed FEB 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1923, to Feb. 16, 1923, that I last saw him alive on Feb. 16, 1923 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Mitral Regurgitation

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No Physical

What test confirmed diagnosis?

(Signed) J. E. Rumbach M. D.

Feb. 16, 1923 (Address) 1531 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Feb. 19 1923

20 UNDERTAKER George J. Rutter ADDRESS 1735 Harlest ave.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72645

101-00 D72645

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. M. J. H. ST., 3 WARD)

2-FULL NAME Elizabeth Jackson

(a) RESIDENCE No. 230 S. Spring ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Joseph Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Charity Cornish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ida Frost
(Address) 230 S Spring St

15 Filed FEB 19 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1923, to Feb 18, 1923, that I last saw h.. alive on Feb 18, 1923, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 8 ? ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) Francis J. Dadaglacka M. D.

, 19 (Address) Municipal Tbc Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL Feb 22 1923

20 UNDERTAKER Dyo & Ruth — ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72646

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72646

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1219 W Lombard St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Crocken

(Residence in Baltimore: No. 1219 W Lombard St.; yrs. 48 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Mal	white	Mard

6-DATE OF BIRTH. Feb (Month) 14 (Day) 1875 (Year)

7-AGE. 48 yrs. mos. 1 ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Helper
(b) General nature of Industry, business, or establishment in which employed (or employer): City Market

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Daniel Crocken

11-BIRTHPLACE OF FATHER, (State or Country) Balto City

12-MAIDEN NAME OF MOTHER. Georgiana Morgan

13-BIRTHPLACE OF MOTHER, (State or Country) Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna B. Leidner

(Address) Earleigh Heights Md

15-

FEB 19 1923 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb (Month) 15 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Inflammatory Rheumatism (Duration) 1 yrs. mos. ds.

(Signed) James M. Hanlon M. D. (Coroner.)

Feb 16 1923 (Address) 701 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Baltimore Md DATE OF BURIAL. Feby 19 1923

20-UNDERTAKER. Gorter Sons ADDRESS. Gorter & Sons Funeral Directors

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Michael J Coolahan

Spec—12-23-21—E.B.R.S.—400 Eks.

D72647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72647

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. M. J. Coolahan

(a) Residence No. 3207 North Ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mr. M J Coolahan

6-DATE OF BIRTH (month, day and year) Sept 8 1857

7-AGE, 65 yrs. 5 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Automobile Salesman

(b) General nature of industry, business, or establishment in which employed (or employer). 066

(c) Name of employer.....

9-BIRTHPLACE (city or town)... (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Edw Coolahan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Emma Coolahan

(Address) 3707 N Charles

15- Filed FEB 19 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 16 '23

17- I HEREBY CERTIFY, That I attended deceased from Feb 4 1923 to Feb 16 1923 that I last saw h alive on Feb 16 1923 and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy, Stricture of Urethra (Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia, Cystitis, Arteriosclerosis (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 2 16 23

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Course

(Signed) Lawrence Gray M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge

DATE OF BURIAL, 2/19, 19 23

20-UNDERTAKER. J. F. Hahn & Sons

ADDRESS 1318 Light St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72648 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72648

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1608 E Hoffman St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James J McGraw

(Residence in Baltimore No. 1608 E Hoffman St; yrs. 57 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. June 16 1866 (Month) (Day) (Year)

7-AGE. 56 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Labor
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS:

10-NAME OF FATHER. James McGraw

11-BIRTHPLACE OF FATHER, (State or Country). Ireland.

12-MAIDEN NAME OF MOTHER. Sarah Devlin

13-BIRTHPLACE OF MOTHER, (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary McGraw

(Address) 1608 E Hoffman

15- FEB 19 1923 Filed 192 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb 16th 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J S K Tate M. D. (Coroner.)

2-17 1923 (Address) 508 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral

DATE OF BURIAL. Feb 19/1 1923

20-UNDERTAKER. Bolt & Sumwalt Inc & Oliver Bros

ADDRESS Broadway

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72649 101-007 D72649

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 N Durham ST., 7 WARD)

2-FULL NAME Wylie Gordon

(a) RESIDENCE NO. 1032 N Durham ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Jamieson Gordon

6 DATE OF BIRTH (month, day, and year): Aug - 1882

7 AGE: Years 40 | Months 6 | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer): 40

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): South Carolina

PARENTS

10 NAME OF FATHER: Ben Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina

12 MAIDEN NAME OF MOTHER: Jane Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): South Carolina

14 Informant: Jamieson Gordon
(Address) 1032 N Durham

15 Filed FEB 19 1923, 19 ..... ROBERT F. KRAUTER, Registrar
Deputy Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 16 1923, to Feb 17, 1923, that I last saw h~~im~~ alive on 16, 1923, and that death occurred, on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

Congestion of Lungs

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pneumonia acute

(duration) ..... yrs. ..... mos. 3 ..... ds.

18 Where was disease contracted if not at place of death? at his home

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Thomas J Summs, M. D.

, 19 (Address) 1625 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetry. DATE OF BURIAL: Feb. 19 1923

20 UNDERTAKER: Robt J Turner Inc ADDRESS 1445 N Broadway.

MEDICAL CERTIFICATE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72650

CERTIFICATE OF DEATH.

X/29

D72650

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 761 Dover St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marcellus Jovey

(a) RESIDENCE. NO. 761 Dover ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State) Calvert Co Md

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Summer

7 AGE — Years: 50 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Arthur Brooks (Address) 761 Dover St

15 Filed FEB 19 1923, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/17/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/17 1923 to 2/17/ 1923, that I last saw h alive on 2/16/ 1923, and that death occurred, on the date stated above, at 5:30A m.

The CAUSE OF DEATH* was as follows:

Circulatory Insufficiency

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Urinary Retention (Nephritis) (duration) About yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Sam Bowley, M. D.

2/17 1923 (Address) 908 E Shaft St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Solley Hill Calvert Co Md

DATE OF BURIAL: Feb 20 1923

20 UNDERTAKER: J. H. Brown & Son

ADDRESS: 108 N. Monty

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72651

CERTIFICATE OF DEATH.

101-60 ✓ D72651

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Bay View Hospital ST., 14 WARD)

2-FULL NAME Grace Trostell

(a) RESIDENCE NO. 1847 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Trostell

6 DATE OF BIRTH (month, day, and year) Nov 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	36	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hammerman 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) Pa

PARENTS

10 NAME OF FATHER Jacob Barr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Lillie Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address) Hosp Records

15 Filed FEB 19 1923, 19 M T W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-17-1923

17

I HEREBY CERTIFY, That I attended deceased from 2-5-, 1923 to 2-17-, 1923

that I last saw h... alive on 2-17-, 1923

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Manic depressive psychosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

(Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster Pa

DATE OF BURIAL Feb 20 1923

20 UNDERTAKER W M Routson

ADDRESS Greene & Saratoga

IMPORTANT—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72652

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

100-001

Registered No. D72652

City of BALTIMORE: (No. 711 Bradley Av St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Guthrie

(Residence in Baltimore: No. 711 Bradley Av St.; yrs. 2 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	colored	Sing'l

6-DATE OF BIRTH. Dec. 10, 1920
(Month) (Day) (Year)

7-AGE. ... yrs. 2 mos. 6 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of Industry, business, or establishment in which employed (or employer): Infant

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS

10-NAME OF FATHER. Joseph Guthrie

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. Isabella Taylor

13-BIRTHPLACE OF MOTHER, (State or Country) Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isabella Guthrie

(Address) 711 Bradley Av

15- Filed Feb 19 1923 192 M H A Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 16, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) none history

(Duration) ... yrs. ... mos. ... ds.

(Signed) [illegible] M. D. (Coroner)

Feb 17, 1923 (Address) 2702 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn	2-19- 1923
20-UNDERTAKER. Daniel Carter	ADDRESS 716 N Fay

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72653

CERTIFICATE OF DEATH. V111-001

D72653

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 21 WARD)

2-FULL NAME William Rollins

(a) RESIDENCE NO. 530 West St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	39	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Rollins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Maryland

12 MAIDEN NAME OF MOTHER Maggie Franzier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carolina Co., Md.

14 Informant Municipal Hospital Records.

(Address)

15 Filed FEB 19 1923 19 M & A. Registrar

FEB 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 19 23

17

I HEREBY CERTIFY, That I attended deceased from February 3, 19 23. to February 17 1923.

that I last saw him alive on February 16, 1923.

and that death occurred, on the date stated above, at 2:00 A. M. m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

(duration) yrs. 1 mos 17 ds.

CONTRIBUTORY (Secondary) Esophageal obstruction (Cancer)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.

2-17 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 2-20 1923

20 UNDERTAKER Daniel Eurot

ADDRESS 516 Gay

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D72654

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72654

CERTIFICATE OF DEATH.

X100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3660 Lyemore ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warnetta Pruitt

(a) RESIDENCE NO. 3660 Lyemore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Alabama

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Albert Pruitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Missouri

12 MAIDEN NAME OF MOTHER Victoria Goffey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Albert Pruitt

(Address) 3660 Lyemore St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 12th, 1923, to Feb 17th, 1923

that I last saw her alive on Feb 17th, 1923,

and that death occurred, on the date stated above, at 830 P m.

The CAUSE OF DEATH* was as follows:

Bronco-pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronco-pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical findings

(Signed) T. B. Steele, M. D.

Feb 19, 1923 (Address) 1827 Union Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — DATE OF BURIAL Feb 19 1923

20 UNDERTAKER Chenowith Son — ADDRESS Chestnut Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Reba Millman

D72655

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72655

101-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Reba Millman

(Residence in Baltimore: No. 2453 Druid Hill Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, ... (Month) ....., 1 (Day) ..... (Year)

7-AGE, 8 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer): (HO)

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Harry Millman

11-BIRTHPLACE OF FATHER (State or Country), Russia Finland

12-MAIDEN NAME OF MOTHER Anna Michelson

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Michelson

(Address) 2453 Druid Hill Ave

15-

Filed ....., 191... M D C
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 18, 1925
..... (Month) ..... (Day) ..... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) found that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Claude Blades (Coroner.)

..... 191... (Address) 1443 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Washington	....., 19... 2/20/25
20-UNDERTAKER	**ADDRESS**
D C Levinson	1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72656

CERTIFICATE OF DEATH.

111-007 D72656

1-PLACE OF DEATH Sebens Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 27 WARD)

2-FULL NAME Mr. James Mackay

(a) RESIDENCE NO. 501 Litchfield ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ann L. Mackay.

6 DATE OF BIRTH (month, day, and year) Nov 26-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	53	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing.

(c) Name of employer Heidelberg Robe Co.

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Daniel Mackay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER — Orr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland.

14 Informant Mrs Ann L. Mackay (Address) 501 Litchfield ave

15 FEB 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1923, to Feb. 18, 1923, that I last saw h— alive on Feb. 18, 1923, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Perforated ulcer of Pylorus & peritonitis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pylorus Ulcer

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Louis Faehr, M.D.

2-19-23 (Address) Sebens Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Feb 20th 23

20 UNDERTAKER Ostrander & Gore

ADDRESS 1723 N Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D72657

HEALTH DEPARTMENT--CITY OF BALTIMORE

D72657

CERTIFICATE OF DEATH

49

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No. 2216 Penna Ave. St.: 15 WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME William J McCurley

(Residence in Baltimore: No. 2216 Penn Ave St.: 5 yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June (Month) 8 (Day), 1851 (Year)

7 AGE: 71 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9 BIRTHPLACE (State or country): Balto

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert C. Blume

(Address) 630 Bartlett st

15 FEB 19 1923 ROBERT R. KRAUTER, Filed ..... 191 ..... Burial Permit Clerk ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. 17 (Month) (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1922 to Feb. 17 1923, that I saw him alive on Feb. 17 1923, and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Malignant prostate bladder

(Duration) yrs. 6 mos. ds

Contributory (SECONDARY) Broncho pneumonia

(Duration) yrs. mos. 6 ds.

(Signed) Melvin S. Sundheim M. D.

Feb. 17, 1923. (Address) 1727 Madison ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Western Cemetery — DATE OF BURIAL: Feb 20, 1923

20 UNDERTAKER: George J Smith — ADDRESS: 1532 Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72658

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D72658

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 N. Fulton St. 19 WARD)

2-FULL NAME Thomas F. Shannon

(a) RESIDENCE. No. 123 N. Fulton St. 19 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 61 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, ~~or Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Shannon

6 DATE OF BIRTH (month, day, and year) Nov 23 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	3 Mo		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) (State or country) Birmingham England

PARENTS

10 NAME OF FATHER Thomas F Shannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Armagh Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) John Shannon 1106 Newyorker Apts

Filed FEB 19 1923, 19 ROBERT F. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16th 1923

17

I HEREBY CERTIFY, That I attended deceased from February 8, 1923, to February 16, 1923, that I last saw him alive on February 16th, 1923, and that death occurred, on the date stated above, at 3 30 A. m.

The CAUSE OF DEATH* was as follows:

(Broncho) Pneumonia

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Oedema Pulmonary

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What lest confirmed diagnosis?

(Signed) F. B. Saunders, M. D.

Feb 16 1923 (Address) 214 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb. 20th 1923

20 UNDERTAKER Geo. J. Smith

ADDRESS Hollins & Gilmor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D72659

D72659

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 Rutland Ave. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Elisa Hill.

(a) RESIDENCE No. 1003 Rutland Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Karl G. Hill.

6 DATE OF BIRTH (month, day, and year) Apr. 15, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Karl G. Schroeder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss Matilda L. Hill.

(Address) 1003 Rutland Ave.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1923, to Feb 16, 1923, that I last saw her alive on Feb 15, 1923, and that death occurred, on the date stated above, at 3.30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Heart Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 709 N. Bivay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery — DATE OF BURIAL: Feb. 19 1923

20 UNDERTAKER: John Ullrich — ADDRESS: 2008 ~~Urban~~ Orleans

Spec.—1-10-21—M&T—1500 Bks.

D72660

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D72660

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 N: Eden St ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M: Hall

(a) RESIDENCE No. 703 N: Eden St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W: Hall

6 DATE OF BIRTH (month, day, and year) 1/28/1865.

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
58		21.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Fredk Klaproth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Klages

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Geo WL Hall

(Address): 703 N: Eden St

15 Filed . 19 ... M.E.P Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18/1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 17th, 1923, to Feb 18th, 1923,

that I last saw h[illegible] alive on Feb 17th, 1923,

and that death occurred, on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia, (Acute)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms autopsy

(Signed) [illegible], M. D.

, 19 (Address) 602 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pattison Cemetery

DATE OF BURIAL: Feby 23

20 UNDERTAKER: John Ulrich

ADDRESS: 2008 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72661

CERTIFICATE OF DEATH.

91-002 D72661

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Eular

(a) RESIDENCE NO. Municipal Hospital. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Feb 8 1829

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	84	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Eular

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 19 1923 ITS, 19 M. P. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 19 23

17 I HEREBY CERTIFY, That I attended deceased from January 31, 19 23, to February 17 19 23, that I last saw him alive on February 16, 19 23, and that death occurred, on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

2-17-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Feb 20 1923

20 UNDERTAKER Jos Joerdens Son — ADDRESS 2178 Pa

Spec.—1-10-21—M&T—1500 Blks.

D72662

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72662

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wright

(a) RESIDENCE NO. 602 W. Saratoga st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship joiner 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Wright

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Varinia

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14

Informant Hospital Records

(Address) M.T.H.

Filed FEB 16 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16, 1923

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1922, to Feb. 16, 1923,

that I last saw him alive on Feb. 16, 1923,

and that death occurred, on the date stated above, at 6.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Dalgleish, M. D.

2-17, 19 23 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemy

DATE OF BURIAL Feb 20 1923

20 UNDERTAKER Jos Joerdens Son

ADDRESS 2173 Bo...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HAAS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72663 ✓ D72663

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Nathan J. Haas (Carrie)

(a) RESIDENCE NO. Marlborough Apts. 42 W ST., WARD Baltimore, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan J. Haas.

6 DATE OF BIRTH (month, day, and year) Sept. 6 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Michael Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Mayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Nathan J. Haas
(Address) Marlborough Apts.

15 Filed , 19 MJP Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1923, to Feb. 19, 1923, that I last saw her alive on Feb. 19, 1923, and that death occurred, on the date stated above, at 5:15 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, left.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 15+ yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. B. Price M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 2/21/ 1923

20 UNDERTAKER David Sonnheim

ADDRESS 115 W. Mt. Royal Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72664

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72664

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 Rockwood ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME T. Clayton Santmyer

(a) RESIDENCE No. 120 Rockwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state AGE should be stated EXACTLY. Correct if necessary. Supplied.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Nellie H. Santmyer

6 DATE OF BIRTH (month, day, and year): Dec. 26-1873

7 AGE — Years: 49 — Months: 1 — Days: 22 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Thos. W. Santmyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Emma Eckhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Nellie H. Santmyer

(Address): 120 Rockwood ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 "23

17 I HEREBY CERTIFY, That I attended deceased from 2/5, 1923, to 2/17, 1923, that I last saw him alive on 2/17, 1923, and that death occurred, on the date stated above, at 1.10 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Asthma Bronchial

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Henry Ruisede, M. D.

, 19 (Address) 5902 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: 2/19 "23

20 UNDERTAKER: Chas. C. Evans & Son — ADDRESS: 1180 W. Pratt

D72665 D72665

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 500 Potomac Ave. Brooklyn St., 25 Ward)

Registered No. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Durm.

(Residence in Baltimore: No. 500 Potomac Ave. Brooklyn. St.; 79 yrs., 10 mos., 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: White.

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower.

6-DATE OF BIRTH: April 9, 1843. (Month) (Day) (Year)

7-AGE: 79 yrs. 10 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ship builder.
(b) General nature of Industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: John Durm.

11-BIRTHPLACE OF FATHER, (State or Country): Philadelphia Pa.

12-MAIDEN NAME OF MOTHER: Margaret Romoser.

13-BIRTHPLACE OF MOTHER, (State or Country): Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Durm. (son).

(Address) 500 Potomac Ave. Brooklyn.

15- FEB 19 1923 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 15, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. 2 mos. ....ds.

(Signed) Otto M. Reinhardt (Coroner) M. D.

1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Ida Hill Cem. DATE OF BURIAL: 1/19/23

20-UNDERTAKER: Margaret L. Flynn ADDRESS 1017 E. Chas St.

...may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D72666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D72666

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2343 Edmondson Ave. WARD 20)

2-FULL NAME Herman A Hess

(a) RESIDENCE NO. 2343 Edmondson Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Hess

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of indnstry, business, or establishment in which employed (or employer) Typewriting Mch.

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Leslie Hess
(Address) 2343 Edmondson Ave

15 Filed FEB 19 1923 M T P. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1923

17 I HEREBY CERTIFY, That I attended deceased from February 8, 1923, to February 15, 1923, that I last saw him alive on February 15, 1923, and that death occurred, on the date stated above, at 4: 0 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 18(?) mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) L. D. Buxton, M. D.

2/16/ 1923 (Address) 301 E. Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Feb 19 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec. 1-10-21 M&T 1500 Bks.

Burns

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72667

CERTIFICATE OF DEATH.

100-00 D72667

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 Leadenhall ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Binns

(a) RESIDENCE NO. 402 S. Sharp ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb, 16, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Edward Binns

11 BIRTHPLACE OF FATHER (city or town) St Louis (State or country) Georgia

12 MAIDEN NAME OF MOTHER Annie Thomas

13 BIRTHPLACE OF MOTHER (city or town) Atlanta (State or country) Georgia

14 Informant Edward Binns

(Address) 402 S. Sharp St

15 Filed FEB 9 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb, 16, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb, 4, 1923, to Feb, 16, 1923, that I last saw him alive on Feb, 16, 1923, and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(Primary)

(duration) yrs — mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 402 S. Sharp St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dan'l Franklin, M. D.

2/11, 1923 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Mt. Auburn Cemetery — DATE OF BURIAL Feb. 19 1923

20 UNDERTAKER C. L. Parham — ADDRESS 220 Hamburg St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72668

2668

CERTIFICATE OF DEATH.

X 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias W. Edwards

(a) RESIDENCE NO. Reisterstown ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred None mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Miranda Edwards

6 DATE OF BIRTH (month, day, and year): July 5 1852

7 AGE: Years 70 Months 6 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: John Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Miranda Douglas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Hospital Records (Address)

FEB 19 1923, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1923, to Feb. 19, 1923.

that I last saw him alive on Feb. 19, 1923,

and that death occurred, on the date stated above, at 9 40 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

Cardiac Hypertrophy.

Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sign; Urine albumin.

(Signed) B. W. Rhodes, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Reisterstown Northern Cemetery Co. DATE OF BURIAL: Feb 19 1923

20 UNDERTAKER: Putnam & Goose ADDRESS: 1923 N. Fayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D72669

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D72669

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 W. Mulberry St. ST. 19 WARD)

2-FULL NAME Thomas John Broome

(a) RESIDENCE NO. 1629 W. Mulberry St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. Broome

6 DATE OF BIRTH (month, day, and year) May, 15th. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevadore

(b) General nature of industry, business, or establishment in which employed (or employer) Loading and unloading ships

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Jacob Broome

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Harriet Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant Mrs. Florence E. Boykin

(Address) 410 - N - Fulton

15 Filed FEB 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 26, 1922, to Feb. 16th. 1923.

that I last saw him alive on Feb. 15th. 1923, 19

and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. 6 ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter C. Jackson M. D.

, 19 (Address) 1618 W. Mubberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Asbury — DATE OF BURIAL Feb 20 1923

20 UNDERTAKER Brown Friedel & Schroder — ADDRESS 114 W.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72670 D72670

CERTIFICATE OF DEATH.

24-001

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 567 Laurens ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia A. Cornish

(Residence in Baltimore: No. 567 Laurens St St.; 82 yrs., 6 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Black	Widow

6-DATE OF BIRTH, Feby (Month) 16th (Day), 1841. (Year)

7-AGE, 82 yrs. 6 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Co Md

PARENTS.

10-NAME OF FATHER, Jno. Froby

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Henkmann

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Simms

(Address) 567 Laurens St

15- FEB 19 1923 Filed....., 191.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby (Month) 16 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Janu 31st 1923, to Feby 16th 1923, that I saw h.. alive on Feby 15th 1923, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

..... Arteriosclerosis .....

..... (Duration) 6 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Senile Gen'l Debility

..... (Duration) 6 mos. ds.

(Signed) R. R. Blanchard M. D.

2-16-23, 191.. (Address) 1812 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel DATE OF BURIAL. Feb 19, 191..3

20-UNDERTAKER James H. Dennis ADDRESS 1502 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72671

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002
D72671

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Keyworth & Reisterstown Rd. (St.) 15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Paulus

(a) RESIDENCE. (No.) Keyworth & Reisterstown Rd. (St.) (WARD.)
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elenor C Paulus

6 DATE OF BIRTH (month, day, and year) Dec 20 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

686

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. D H Paulus
(Address) 1800 Rosedale St.

15 FEB 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 30, 1923, to Feb. 17, 1923, that I last saw h— alive on Feb 17, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia
Senile Arteriosclerosis
(Senility)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James D Ackenheil, M. D.

2-18-1923 (Address) 4017 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	2-20 1923

20 UNDERTAKER Mrs Chas A G Rohde ADDRESS 600 Arlington Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72672 21 D72672

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 N. Eden ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hamilton Theodore Watts

(Residence in Baltimore: No. 431 N. Eden St

St.; life yrs. abt 50 yrs mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 4 (Day), 1863 (Year)

7-AGE, 59 yrs. 9 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Express business
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Anne Arundel Co Md.

PARENTS.

10-NAME OF FATHER, John Wesley Watts

11-BIRTHPLACE OF FATHER (State or Country), Anne Arundel Co Md

12-MAIDEN NAME OF MOTHER Harriett Walker

13-BIRTHPLACE OF MOTHER (State or Country), Anne Arundel Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora L. Watts wife

(Address) 431 N. Eden St

15-

Filed FEB 19 1923, 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 16 (Day), 1923. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 9 1923, to Feb 16 1923, that I saw h AM alive on Feb 16 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. mos. ds.

(Signed) R. O. Hummel M. D.

2/19, 1923 (Address) 1429 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery

DATE OF BURIAL. Feb 20 1923

20-UNDERTAKER Joseph T. H. Rochester

ADDRESS 193 Gilmor St

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72673

CERTIFICATE OF DEATH.

46 D72673

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1109 S. Bouldin ST., (Ward) 46

2-FULL NAME Theresa Henderson

(a) RESIDENCE NO. 1109 S. Bouldin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 36 yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should be stated EXACTLY. ... supplied. AGE should be stated

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Henderson

6 DATE OF BIRTH (month, day, and year): Feb. 28-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant: Martha T. Garcia (Address) 1109 Bouldin

15 FEB 19 1923 Filed ..., 19...

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from January 2nd, 1923, to Feby 17th, 1923, that I last saw her alive on Feby 16th, 1923, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteris

(duration) ... yrs. 1 mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Johns Hopkins Hospital

(Signed) Robt Whitney, M. D.

Feby 18, 1923 (Address) 103 S. Potomac Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Feb 20 1923
20 UNDERTAKER: Gerkler & Gerkler	ADDRESS: 1339 Eager

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72674

CERTIFICATE OF DEATH.

129 D72674

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 N. Luzerne Ave. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Cermak

(a) RESIDENCE NO. 822 N. Luzerne Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? 7 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbora

6 DATE OF BIRTH (month, day, and year): April 15, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: Em. Skrubek

9 BIRTHPLACE (city or town) (State or country): Bohemia Europe

PARENTS

10 NAME OF FATHER: Frank Cermak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia Europe

12 MAIDEN NAME OF MOTHER: Aloisie Brychan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia Europe

14 Informant: Barbora Cermak

(Address): 822 N. Luzerne Ave

15 FILED FEB 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1923 to Feb 17, 1923

that I last saw h— alive on Feb. 17, 1923

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Uraemic Convulsions

Chron. Pyelonephritis (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilmer Krusen M. D.

Feb 19, 1923 (Address) 801 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakhill — DATE OF BURIAL: Feb 26 1923

20 UNDERTAKER: Pirkler & Pirkler — ADDRESS: 1799 Eager

INFORMATION, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72675

CERTIFICATE OF DEATH.

90 D72675

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 S. Eight ST., 9a WARD)

2-FULL NAME George Waldmann

(a) RESIDENCE NO. 1407 S. Eight ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Waldmann

6 DATE OF BIRTH (month, day, and year) Sept. 11-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Waldmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barbara Waldmann
(Address) 1407 S. Eight St.

15 Filed FEB 19 1923 ROBERT R. KRAUTER, Registrar
BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 9th, 1923, to Feby 17th, 1923, that I last saw him alive on Feby 17th, 1923, and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

Valvular Disease Heart

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Lobular Pneumonia

(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isabel Wolley, M. D.

Feby 18, 1923 (Address) 1005 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lehwalt	Feb 19 1923
20 UNDERTAKER Turkel & Pinkler	ADDRESS 1139 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72676 D72678

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 Ramsey ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Hebu

(a) RESIDENCE. No. 2120 Ramsey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 18 18[illegible]

7 AGE: Years 58 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany Hebu

PARENTS

10 NAME OF FATHER: Jacob Hebu

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mebender

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine Corder (Address) 2120 Ramsey St

15 Filed FEB 19 1923, 19 Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1923, to Feb 17, 1923.

That I last saw h[illegible] alive on Feb 16, 1923.

and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH* was as follows:

(over)

Pneumonia Comp

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

2/18/23 (Address) 1729 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Feb 20/ 19 23

20 UNDERTAKER: F. B. Weisheit — ADDRESS: 2256 Fred[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other Abnormal conditions

Spec.—1-1921 M&T 1500 Bks.

D72677

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72677

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1708 S. Charles St. ST., 23 WARD)

2-FULL NAME Irene M. Willey

(a) RESIDENCE NO. 1708 S. Charles St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 15 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas. J. Willey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha Lilley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Chas. J. Willey

(Address) 1708 S. Charles

15 Filed FEB 9 1923, 19 W.H.P. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 17, 1923, to Feb 18, 1923,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R.E. Campbell M. D.

Feb 19, 1923 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem.

DATE OF BURIAL 2/20 1923

20 UNDERTAKER J. Fred McCully

ADDRESS 130 E. Fort.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72678

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 W. Cross ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harvey Moore

(a) RESIDENCE NO. 523 W. Cross ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 8th 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Charlotte N. C.
(State or country)

PARENTS

10 NAME OF FATHER Spence Moore

11 BIRTHPLACE OF FATHER (city or town) Charlotte
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Elyse Lewis

13 BIRTHPLACE OF MOTHER (city or town) Charlotte N. C.
(State or country)

14 Informant Elsie Springs
(Address) 523 W. Cross St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/16 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/20, 1922, to 2/16, 1923,

that I last saw him alive on 2/16, 1923,

and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
(Uremia)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Urinary Fistulas of Perineum (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. B. Cannee, M. D.

2/19 1923 (Address) 40 Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Feb 14 1923
20 UNDERTAKER	ADDRESS
R. C. Gross 1400	McElderry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Vail

D72679

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D72679

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. W. P. I. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Thelma Gail

(Residence in Baltimore: No. 1901 Ethig Ave. St.; yrs., 3 mos., 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. June 13 (Month) (Day) 1917 (Year)

7-AGE. 5 yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Geo. C. Gail

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Louise Pinder

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Geo. C. Gail

(Address)..... 1901 Ethig Ave.

15- Filed 2 19 1923 [illegible] 192.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 16 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st & 2nd degree burns of body.
(accidental)
(Duration)..... yrs..... mos. 1 ds.

CONTRIBUTORY (Secondary) Clothes caught fire from stove.
(Duration)..... yrs..... mos..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Feb. 19 1923 (Address).....

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos. 1 ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....
1901 Ethig Ave.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, 2/19 1923

20-UNDERTAKER, Samuel Hemsley ADDRESS, 1128 E. Baltimore St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Walbert, St. Paul & 22nd St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

72680

CERTIFICATE OF DEATH.

100-00 D72680

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1927 Oak Hill Ave ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Platt

(a) RESIDENCE NO. 1927 Oak Hill Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced. (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick Platt

6 DATE OF BIRTH (month, day, and year): Aug. 5 50

7 AGE: Years 72; Months; Days; If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Pedr Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anne Lucie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Ruby L. McCann

(Address): 1927 Oak Hill Ave

15 Filed: FEB 19 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1923, to Feb 19, 1923, that I last saw h[illegible] alive on 9.30 PM Feb 18 1923 and that death occurred, on the date stated above, at 1-30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm T Watson, M. D.

Feb 19, 1923 (Address) 1928 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cemetery — DATE OF BURIAL: Feb 21 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Mt Royal

Please write plainly. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D72681

CERTIFICATE OF DEATH

11-00 D72681

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 614 Glendale Ave. St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia R Jennings

(Residence in Baltimore: No. 614 Glendale Ave St.; 40 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Feb (Month) 10 (Day) 1863 (Year)

7-AGE: 60 yrs. ..... mos. 7 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 37

9-BIRTHPLACE (State or country): Frederick County

PARENTS

10-NAME OF FATHER: Edward Hard

11-BIRTHPLACE OF FATHER (State or country): Frederick County

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Frederick County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joshua Jennings

(Address) 614 Glendale Ave

15- 1923 WAP

Filed ..... 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: February (Month) 17th (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 7th, 1923, to, Feb. 17th 1923, that I saw h.. alive on Feb. 17th 1923, and that death occurred, on the date stated above, at 7.25 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... yrs ..... mos. 5? ds.

Contributory (SECONDARY) Broncho Pneumonia

(Duration) ..... yrs ..... mos. 5? ds.

(Signed) Hank N. Hill M. D.

Feb 18th, 1923 [Address] 2838 Greenmount

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Loudon Park — DATE OF BURIAL: Feb 21, 1923

20-UNDERTAKER: Wilhelm Bro — ADDRESS: 502 E Nath

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Lann.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72682 | 101-00 D72682

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 38 1 East Ave ST., 1 WARD)

2-FULL NAME Louis Lann

(a) RESIDENCE NO. 38 1 East Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Catherine Lann

6 DATE OF BIRTH (month, day, and year) Dec. 21 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	86	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Lann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine Lann

(Address) 38 1 East Ave

15 Filed. FEB 10 1923, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 19 23

17 I HEREBY CERTIFY, That I attended deceased from February 7, 1923, to February 7, 1923, that I last saw h alive on 19 and that death occurred, on the date stated above, at 2 460 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 21 Nurses

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C W Schneider, M. D.

2/7, 1923 (Address) 330 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem | DATE OF BURIAL Feb 4 1923

20 UNDERTAKER Gilbert Cadwalader | ADDRESS Ratta

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72683

CERTIFICATE OF DEATH.

5 1 C

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2723 W North Ave ST., 15 WARD)

2-FULL NAME Gustav Ketskemethy

(a) RESIDENCE NO. 2723 W North Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Emma Kels Ketskemethy

6 DATE OF BIRTH (month, day, and year): July 29-1859

7 AGE — Years: 63 — Months: 7 — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Personal Business

9 BIRTHPLACE (city or town) (State or country): Roumania

PARENTS

10 NAME OF FATHER: Don't Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Roumania.

12 MAIDEN NAME OF MOTHER: Don't Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Roumania

14 Informant: Geo. McGill
(Address): 2723 W North Ave

15 Filed ..., 19... W.P. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 18. 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13- 1923 to Feb 18 1923, that I last saw him alive on Feb 18 1923, and that death occurred, on the date stated above, at 8: P m.

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism

(duration) yrs. ... mos 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) G E Buxton, M. D.

2/19, 1923 (Address) 301 East Lenox St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: Feb 21 1923

20 UNDERTAKER: Wm Cooke — ADDRESS: 502 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D72684

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-00 D72684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 William St. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie R. Hart

(a) RESIDENCE NO. 1220 William St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 30 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	3	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James F. Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Katie Trader

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant James F. Hart (Address) 1220 William St.

15 Filed FEB 7 1923, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3, 19 23, to Feb. 7, 19 23.

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. F. Hart, M. D.

2/7, 19 23 (Address) 801 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Deltaville Middlesex Co. Va.

DATE OF BURIAL: 2/10 1923

20 UNDERTAKER: I. Frew McCully

ADDRESS: 130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72685

99 D 72685

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3012 Guilford ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B Renshaw

(a) RESIDENCE. NO. 8 th Harlem ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~: Margaret G. Renshaw

6 DATE OF BIRTH (month, day, and year): July 7 1833

7 AGE — Years: 89 Months: 7 Days: 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Coal Dealer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co. Md

PARENTS

10 NAME OF FATHER: Otho Renshaw

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co Md

12 MAIDEN NAME OF MOTHER: Mary Amos

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co Md

14 Informant: J. J Bohannan

(Address) 3012 Guilford Ave.

15 Filed FEB 19 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 16, 1923, to Feby 18th, 1923,

that I last saw h~~e~~ alive on Feby 18th, 1923,

and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis, with attacks of Asthmatic breathing for the past 2 or 3 years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Advanced age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at his home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John A Pennington, M. D.

FEB 19 1923, 19 (Address) 1826 Bolton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Loudon Park

DATE OF BURIAL: FEB 20 1923, 19

20 UNDERTAKER: Geo W Little

ADDRESS 2700 EDMONDSON AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72686 90 D72686

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Union Av ST., 25 WARD)

2-FULL NAME Helen Dorothy Haus

(a) RESIDENCE NO. 1002 Union Av ST., 25 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank J Haus

6 DATE OF BIRTH (month, day, and year) Aug 16 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Home 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John G Luter

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Lenny Lady

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) German

14 Informant Frank J Haus
(Address) 1002 Union Av

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1 1923, to July 16 1923, that I last saw h[illegible] alive on July 16 1923, and that death occurred, on the date stated above, at 11-20 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Dr Mackieffer, M. D.

July 19 1923, 19 (Address) 2320 Bank Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Feb 20 1923

20 UNDERTAKER Wm. Hirsch & Sons — ADDRESS 1737 W Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72687

CERTIFICATE OF DEATH.

129 D72687

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 388 East ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Anna Burkhardt

(Residence in Baltimore: No. 388 East ave St.: 65 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May (Month) 10 (Day), 1852 (Year)

7-AGE. 70 yrs. 6 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) House Keeper

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Jacob Krumeche

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Hellich

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August F. Burkhardt

(Address) 323 St Paul

15-

Filed FEB 10 1923, 191... W. A. B. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Febr 18 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Febr 5 1923. to Febr 18 1923 that I saw her alive on Febr 17 1923, and that death occurred, on the date stated above, at 5-45 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Mitral Insufficiency

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary) Nephritis; Arterio Sclerosis

(Duration) ...yrs...mos...ds.

(Signed) Nathan Hellich M. D.

Feb 19 1923, 191... (Address) 1117 Druid Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Carmel

DATE OF BURIAL, Feb 21, 1923

20-UNDERTAKER Wendell Dippel & Son

ADDRESS 378 Park

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

D72688 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D72688

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Waters

(a) RESIDENCE NO. 1040 N. Stricker St/ ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state DISEASE causing death. AGE should be stated EXACTLY.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
65	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chrisfield, Md.

PARENTS

10 NAME OF FATHER John Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline William

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records.

(Address)

15 Filed 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 19 23

17

I HEREBY CERTIFY, That I attended deceased from February 1, 19 23, to February 16 19 23, that I last saw him alive on February 15, 19 23, and that death occurred, on the date stated above, at 1:10 A. M.

The CAUSE OF DEATH* was as follows:

(a) Carcinoma of stomach

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Metastasis to peritoneum (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clyde McNeill, M. D.

2-16-23, 19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL FEB 19 1923

20 UNDERTAKER Commissioner Health.

ADDRESS

Per. Wm. E. WOODALL

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72689 D72689

CERTIFICATE OF DEATH × 38

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 26 WARD)

2-FULL NAME Vernon Pinder

(a) RESIDENCE NO. Helock Station, Md. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	32	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER Stephen Pinder

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Jolly

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Municipal Hospital Records.
(Address)

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1923

17

I HEREBY CERTIFY, That I attended deceased from February 2, 1923 to February 15 1923, that I last saw him alive on February 15, 1923, and that death occurred, on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Aortic Aneurysm
(Syphilitic)

(duration) 7 (?) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) [signature] M. D.

3-16-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ..... 19 .....

20 UNDERTAKER Commissioner Health,

ADDRESS FEB 19 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1923

Burial Permit Clerk.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

72690 D72690

CERTIFICATE OF DEATH.

38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 S. Eutaw ST., 12 WARD)

2-FULL NAME Virginia Meekins

(a) RESIDENCE NO. 602 S. Eutaw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
(or) WIFE of Archie Meekins

6 DATE OF BIRTH (month, day, and year) Feb. 5th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or estsblishment in which employed (or employer) 0

(c) Name of employer Mrs. Gunty-Roland 5th

9 BIRTHPLACE (city or town) Weberrin
(State or country) Virginia

PARENTS

10 NAME OF FATHER Alex. Payne

11 BIRTHPLACE OF FATHER (city or town) Weberrin
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Millie Watson

13 BIRTHPLACE OF MOTHER (city or town) Weberrin
(State or country) Virginia

14 Informant James W. Payne
(Address) 602 S. Eutaw St.

15 Filed [illegible], 19 Robert F. Harrison
Registrar

Burial Permit [illegible] THE MORGUE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6th, 1923, to Feb. 14th, 1923, that I last saw h[illegible] alive on Feb. 13th, 1923, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro. Spinal Lues

(duration) ? yrs. ? mos. 7 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) O. H. Harrell, M. D.

2/16, 1923 (Address) 140 Whitelock st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. — ADDRESS

JOHNS HOPKINS HOSPITAL

FEB 19 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D72691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72691

CERTIFICATE OF DEATH.

145-102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4 Joseph's Hosp. (St.) 9 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catherine Dunn

(a) RESIDENCE. No. 1301 Hillman St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard Dunn

6 DATE OF BIRTH (month, day, and year): May 1

7 AGE: Years 35 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Sarah McGuire

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Richard Dunn 1301 Hillman St.

Filed FEB 19 1923 19 M T P. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 17. 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1923, to Feb. 17, 1923.

that I last saw her alive on Feb. 17, 1923

and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Feb. 16-23

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Bernard Wm. , M. D.

, 19 (Address) 914 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral DATE OF BURIAL: Feb 20 1923

20 UNDERTAKER: H. C. Widefeld ADDRESS: 914 Greenmt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Forceps Delivery

Eugene H. Bosom

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72692 D72692

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. St. Joseph Hosp. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene E. Bosom

(a) RESIDENCE. No. 1638 Cliff View Ave ST.,

WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28-1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James W. Boson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Mary Delaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant James W. Boson (Address) 1638 Cliffview Ave

15 FEB 19 1923 . 19 M J P. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 . 1923 to Feb. 18 . 1923

that I last saw h[illegible]alive on Feb. 18 . 1923

and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Acute cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrenous Appendicitis & Varicose Ulcer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 15-23

Was there an autopsy? No.

What test confirmed diagnosis?

*(Signed) Jos. Denton , M. D.

. 19 (Address) 700 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Feb 22 1923

20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmt

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72693

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72693

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 604 St. Paul ST., 11 WARD)

2-FULL NAME Katharine T. O'Brien

(a) RESIDENCE NO. 604 St. Paul ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. O'Brien

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Mulligan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Elizabeth -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Eileen O'Brien (Address) 604 St. Paul Street

15 Filed 2/21 1923, 19 M-1 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 10, 19 23, to Feb 19, 19 23,

that I last saw h alive on Feb 19, 19 23,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes - 7yrs

Uremia - 7yrs

Bronchitis - death 5 days - hypostatic

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertrophic nephritis duration (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Thomas A. Reese, M. D.

19 , 19 (Address) 700 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL 2/19 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72694

D72694

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 S. 14th ST., 26 WARD)

2-FULL NAME Fiori Trotta

(a) RESIDENCE NO. 616 S. 14th St. ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33, yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Trotta.

6 DATE OF BIRTH (month, day, and year): Feb. 21 - 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Luigi Trotta

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Victoria Gottalta

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Libero Trotta

(Address) 141 S. 5th St.

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from June 5 1922 to Feb 16 1923,

that I last saw him alive on Feb 16 1923

and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

of Arteriosclerosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Franklin Hazlehurst Jr M. D.

19 (Address) 3122 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem.

DATE OF BURIAL: Feb. 20 1923

20 UNDERTAKER: Tilly & Zitler

ADDRESS: 403 S. Mo[illegible]

Burial Permit Clerk

Spec.—1-10-21 M&T 1500 Bks.

D72695

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72695

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. #112-St.Johns Road. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Therese Edelen

(a) RESIDENCE NO. 112-St.Johns Road. ST., 27 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 74 yrs. 7 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj.M.Edelen

6 DATE OF BIRTH (month, day, and year) July-18-1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Bryantown, Charles Co Maryland

PARENTS

10 NAME OF FATHER T.Elzare Gardiner

11 BIRTHPLACE OF FATHER (city or town) St.Mary's Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Adelle Walbach

13 BIRTHPLACE OF MOTHER (city or town) Pikesville (State or country) Balto.Co.,Maryland

14 Informant Mr.J.W.Edelen,(son)
(Address) 112-St.Johns Road,City.

15 Filed 2/19, 1923 Robert F. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/1, 1923, to 2/18, 1923, that I last saw h[illegible] alive on 2/18, 1923, and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Myocardial failure with Pulmonary Edema

(duration) yrs. mos 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical tests

(Signed) Ralph Hubbard M. D.

2/19, 1923 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bryantown, Charles Co.Md.

DATE OF BURIAL Feb-20-23

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W.NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

8 1 1923

Spec.—1-10-21—M&T—1500 Bks.

D72696

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72696

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2023-West-Lanvale-St. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME LILLIE VIRGINIA MEHNER

(a) RESIDENCE NO. 2023-W-Lanvale-St. ST., 16 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? 41 yrs. 3 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stonewall J. Mehner

6 DATE OF BIRTH (month, day, and year) Nov-16-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	41	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William Shultz

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Tweedall

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mr. S. J. Mehner, (wife)
(Address) 2023-W-Lanvale-St. City.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk

19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1923, to Feb 18, 1923, that I last saw her alive on Feb 18, 1923, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Homer L. Wood, M. D.

Feb. 1923 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL WESTERN CEMETERY — DATE OF BURIAL Feb-21-23

20 UNDERTAKER STEWART & MOWEN COMPANY, WILLIAM F. WOODEN, Successor — ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. See instructions on back of certificates.

D72697

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72697

CERTIFICATE OF DEATH.

90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 885 W Baltimore St St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa E. Harris

(Residence in Baltimore: No. 885 W Baltimore st - St.; 20 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: dont Know (Month) (Day) (Year)

7-AGE: 53 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamstress
(b) General nature of Industry, business, or establishment in which employed (or employer): 16

9-BIRTHPLACE, (State or Country): York Pa, dont Know

PARENTS

10-NAME OF FATHER: dont Know

11-BIRTHPLACE OF FATHER, (State or Country): " "

12-MAIDEN NAME OF MOTHER: "

13-BIRTHPLACE OF MOTHER, (State or Country): "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. J. Fowler

(Address) 600 W Saratoga st

15- 1923 Robert P. Harrison, 192 Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 19 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) yrs. dont Know mos. ds.

CONTRIBUTORY (Secondary) " "

(Duration) yrs. mos. ds.

(Signed) W. H. Fowler M. D. (Coroner.)

2-19 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loudon Cemetery DATE OF BURIAL. 2-22- 1923

20-UNDERTAKER, Wm. Cook ADDRESS 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72698

D72698

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 15 N Hare ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert H Leimkuhler

(a) RESIDENCE No. 15 N Hare ST., ... WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 6yrs yrs. mos. ds. How long in U. S., if of foreign birth? 4yrs yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Lena Leimkuhler

6 DATE OF BIRTH (month, day, and year): Sept 13 — 1848

7 AGE: Years 75 Months 5 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: National Casket Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Albert Leimkuhler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Lena Leimkuhler 15 N Hare St

15 Filed 1-19-23, 19 ... Robert P. Harrison, Burial Permit Clerk. Registrar

19 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2 — 17 19 23

17 I HEREBY CERTIFY, That I attended deceased from 1-2, 19 23 to 2-17, 19 23

that I last saw him alive on 2-17 19 23

and that death occurred, on the date stated above, at 2 0 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 3 mos.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ordinary

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) F. E. Bennett M. D.

2-19 19 (Address) 600 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: Feb 20 1923

20 UNDERTAKER: Chas C Miller

ADDRESS: 2334 Jefferson

Spec.—1-10-21—M&T—1500 Bks.

Thorpe

D72699 HEALTH DEPARTMENT—CITY OF BALTIMORE D72699

CERTIFICATE OF DEATH.

99-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 804 Ridgley ST. 21 WARD)

2-FULL NAME Rebecca Thorpe

(a) RESIDENCE NO. 804 Ridgley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. W. Thorpe

6 DATE OF BIRTH (month, day, and year): Oct 12, 1852

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Talbot Co Md

PARENTS

10 NAME OF FATHER: Wm Douglas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Talbot Co Md

12 MAIDEN NAME OF MOTHER: Evelyn Wattes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Talbot Co Md

14 Informant: Bertha Jones (Address) 804 Ridgley

15 Filed , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-17-1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1923, to Feb 17, 1923, that I last saw h[illegible] alive on Feb 17, 19 P and that death occurred, on the date stated above, at 5.40 P m.

The CAUSE OF DEATH* was as follows:

Senile Bronchitis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clifford Grain, M. D.

, 19 (Address) 1217 Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wilson Cemetery — DATE OF BURIAL: 2/20 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Hoff

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72700

CERTIFICATE OF DEATH.

101-00/D72700

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3104 Wilbrook Ave (St.) 15 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Katherine Pearson Woods

(a) RESIDENCE NO. 4200 Pimlico Ave St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should be stated EXACTLY. AGE should be stated.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28 1853

7 AGE — Years: 70 — Months: 0 — Days: 20 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wheeling W. Va

PARENTS

10 NAME OF FATHER: Alexander G. Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Josephine McCabe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mrs. Eugenia McC. Means.
(Address) 4200 Pimlico Ave

15 Filed ..... 19 ..... Registrar

Robert P. Harrison

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1920, to Feb. 18, 1923.

that I last saw her alive on Feb. 17, 1923,

and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. G. Queen, M. D.

2/19 1923 (Address) 3501 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — DATE OF BURIAL: Feb 20 1923

20 UNDERTAKER: Wm. Richardson — ADDRESS: Norbeck

19 1923

Spec.–1-10-21–M&T–1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72701 D72701

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2106 Pulaski ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Bross

(a) RESIDENCE No. 2106 Pulaski ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIAN'S should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Bross

6 DATE OF BIRTH (month, day, and year): Oct 8, 1838

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
84	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Kraft

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Frazier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mr. Rudolph Bross

(Address): 1812 W. Franklin

15 Filed: FEB 19 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 18 1923

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1922, to Feby. 18, 1923.

that I last saw her alive on Feby. 17, 1923,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart.

(duration) about yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchial Cold

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) C. C. Smith M. D.

2/19. 1923 (Address) 1605 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Roudon Park — DATE OF BURIAL: Feb. 20 1923

20 UNDERTAKER: Wm J. Fickus — ADDRESS: Nos North Ave

Spec.—1-10-21—M&T—1500 Bks.

D72702

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72702

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., 17 WARD)

2-FULL NAME Magda Hollenberg.

(a) RESIDENCE No. 325 Hayward ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 27 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	71	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Elijah Hollenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cath. Hoffley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hosp. Records

15 Filed ....., 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-17-1923

17 I HEREBY CERTIFY, That I attended deceased from 1-31-, 1923, to 2-17-, 1923, that I last saw h~~e~~ alive on 2-17-, 1923 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Path

(Signed) Clyde M. Neil, M. D.

2/17 1923 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL 2/20 1923

20 UNDERTAKER J. Walter Davis ADDRESS 330 Virginia Ave.

3 19 1923

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72703

CERTIFICATE OF DEATH.

45 D72703

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1911 Fremont Ave ST.: 9 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Cecilia Connelly

(a) RESIDENCE. No. 1911 Fremont Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward J Connelly

6 DATE OF BIRTH [illegible] 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER John Hanlon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Hehir

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Barbara Farren

(Address) 1911 Fremont Ave

15 Filed FEB 19 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) February 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 30th, 1923 to Feb 18th, 1923.

that I last saw her alive on Feb 18th, 1923.

and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

2 (duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Physical Exam

(Signed) Geo Livingston M.D. M. D.

2/19/23 (Address) 40 E 45th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Feb 21, 1923
20 UNDERTAKER	ADDRESS
E. Le Roy Stiffler	125 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D72704

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72704

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1305 2nd ST., Brooklyn WARD 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Halligan

(a) RESIDENCE No. 1305 Second ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a ~~Married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Michael P. Halligan

6 DATE OF BIRTH (month, day, and year) 7-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Halligan (Address) 1305 Second St

15 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 17, 1923, that I last saw h[illegible] alive on Feb 16, 1923, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocarditis

Senilis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hawkins, M. D.

2/7, 1923 (Address) 1 E Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 2/20 1923

20 UNDERTAKER J. J. Fahey & Son

ADDRESS 1318 Light St.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72705

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72705

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE (No. Mercy Hospital St., 18 Ward) 66

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. H. Meyer

(Residence in Baltimore: No. 422 N. Lanvale St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	W.	Single

6-DATE OF BIRTH. April (Month) 8 (Day) 1873 (Year)

7-AGE.	If LESS than 1 day.
49 yrs. 10 mos. 10 ds.	....hrs. or....mts.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER, Chas H. Meyer

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Eliz Runge

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis H. Meyer

(Address) 142 Lexington St

15- Robert P. Harrison,

Filed ..... 192.....

Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Feb. (Month) 18 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Claude Bloedel M. D.

(Coroner)

Feb 21 1923 (Address) 436 N. Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Feb 20 1923
20-UNDERTAKER,	ADDRESS,
Harry W. Ecker	W. Mortuary

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72706

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D72706

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1533 S. Clinton ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Stratemeyer

(a) RESIDENCE NO. 1533 S. Clinton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie C. Stratemeyer

6 DATE OF BIRTH (month, day, and year) June 17-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Groceryman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Md

PARENTS

10 NAME OF FATHER Rudolph Stratemeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mollie C. Stratemeyer

(Address) 1533 S. Clinton St.

15 Filed 2/19, 1923 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1923, to Feb 18, 1923,

that I last saw h[illegible] alive on 2/17, 1923,

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Pulm Oedema and Asthenia

(duration) Pulm TB yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W S Sadler M. D.

2/19, 1923 (Address) 851 32 Bank St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery — DATE OF BURIAL Feb 21 1923

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

19 1923

Spec. 1-10-21—M&T—1500 Bks.

D72707

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72707

CERTIFICATE OF DEATH.

161-601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 S. Curley ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Wise

(a) RESIDENCE No. 1108 S. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kunigunda Wise

6 DATE OF BIRTH (month, day, and year) Aug. 22. 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sherwood Bros

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Wm. Wise, Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Kunigunda Wise

(Address) 1108 S. Curley St

15 Filed , 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/13, 1923, to 2/17, 1923, that I last saw h[illegible] alive on 2/17, 1923, and that death occurred, on the date stated above, at 8.50 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

4 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) [illegible], M. D.

Feb 19, 1923 (Address) 332 S Bethel Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery

DATE OF BURIAL Feb 20 1923

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

19 1923

Spec.—1-10-21—M&T—1500 Bks.

D72708

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72708

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 S. Payson ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Dorn

(a) RESIDENCE NO. 314 S. Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Dorn

6 DATE OF BIRTH (month, day, and year): July 4 - 1847

7 AGE — Years: 75 — Months: 7 — Days: 13 — If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John C. Dorn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Emma H. Dorn

(Address) 314 S. Payson St.

15 Filed ... 19 ... Registrar

FEB 19 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 10, 1923, to Feby 17, 1923, that I last saw h[illegible] alive on Feby 16, 1923 and that death occurred, on the date stated above, at 9-15 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Geo. S. McKieffer M. D.

Feby 19 1923 (Address) 2320 Madd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Feb. 20 1923

20 UNDERTAKER: George L. Schwab — ADDRESS: 1401 Eutaw Place

IMPORTANT. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

(See Letter attached) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72709

D72709

74-101

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., No WARD)

2-FULL NAME. Peter Knight

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) ~~1858~~ 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	~~64~~ 62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records.

(Address)

15 Filed ..., 19 ... Registrar Robert F. Barrison, Burial Permit Clerk.

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 19 23

17

I HEREBY CERTIFY, That I attended deceased from February 17, 19 23 to February 18 19 23.

that I last saw him alive on February 17, 19 23,

and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

apoplexy (Cerebral)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. McKay, M. D.

2-19, 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Olivet — DATE OF BURIAL Feb. 20 19 23

20 UNDERTAKER George L. Schwab — ADDRESS 210 Cook Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

SUB-DEPARTMENT
SUPERVISORS OF CITY CHARITIES

GEORGE R. McCLEARY,
SUPERINTENDENT
W. H. CURRY,
ASST. SUPERINTENDENT

CITY OF BALTIMORE
MARYLAND
MUNICIPAL DEPARTMENTS

BAY VIEW HOSPITAL
HIGHLANDTOWN P. O.

March 1,1923

Dr. Hampson Jones.
Health Department.
City.

Dear Doctor,

Peter Knight was admitted to this hospital with a stroke of apoplexy and died that night. His age on our record was 64 and was doubtless obtained from the patient. I have no personal knowledge of his age and no interest in it. His friend states from what he says is certain knowledge that his age was 62. I regard it as nothing more than right that he should be given the benefit of the doubt and so far as I am concerned the age should be changed to 62.

Yours very truly,

J. A. McKay, M. D.

J.A. McKay.
Assistant Resident Physician.

JAMcK/MAH.

Spec.—1-10-21—M&T—1500 Bks.

D72710

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72710

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3222 Strickland St. Balto. Md. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob K. Sheeler

(a) RESIDENCE No. 3222 Strickland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary P. Sheeler

6 DATE OF BIRTH (month, day, and year): Mar 22

7 AGE: Years 59 Months Days — If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Conductor R. R.

(b) General nature of industry, business, or establishment in which employed (or employer): Railroad

(c) Name of employer: P. R. R.

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Evan B. Sheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Martha Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Mrs Mary P. Sheeler
(Address) 3222 Strickland St.

15 FEB 19 1923 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1923, to Feb 17, 1923

that I last saw him alive on Feb 17, 1923

and that death occurred, on the date stated above, at 7.40 A.M.

The CAUSE OF DEATH* was as follows:

Influenza pneumonia

Complicated Aneurism ascending aorta

Regurgitation + mitral regurgitation

(duration) yrs. mos 2 ds 5

CONTRIBUTORY (Secondary) Cerebral Thrombosis

left side Hemiplegia (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? 3222 Strickland St

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Findings

(Signed) D. Lincoln P. Glaser M. D.

, 19 (Address) 3326 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Occoquan Va — DATE OF BURIAL: Feb. 20 1923

20 UNDERTAKER: Geo. L. Schwab — ADDRESS: 2101 Druid Pk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72711 D72711

CERTIFICATE OF DEATH.

X 146

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital WARD) 11

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Marie Gera

(Residence in Baltimore: No. Lansdowne Md. St.; ....yrs., 1 mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 15 (Day), 1888 (Year)

7-AGE, 32 yrs. 11 mos. ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Hungarian

PARENTS.

10-NAME OF FATHER, Frank Jelbazi

11-BIRTHPLACE OF FATHER (State or Country), Hungarian

12-MAIDEN NAME OF MOTHER Anna Katalin

13-BIRTHPLACE OF MOTHER (State or Country), Hungarian

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Gera

(Address) Lansdowne Md

15-

Filed ....., 191.... Robert P. Harrison
Registrar.

1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 18 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1/8/23 191..., to 2/18/23 191..., that I saw h-er alive on 2/18/23 191..., and that death occurred, on the date stated above, at 6:55 a.m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicemia

(Duration) ....yrs. ....mos. 5 1. ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) ....yrs. 9 mos. ....ds.

(Signed) Jno. A. Timanus Jr. M. D.

....., 191... (Address) Md. General Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, MOUNT OLIVET CEM

DATE OF BURIAL, 2/21, 1923

20-UNDERTAKER ROBERT BROOKS ISON

ADDRESS COR CALHOUN HOLLINS

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Fennemans)

D72712

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72712

CERTIFICATE OF DEATH.

74-101

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., 4 WARD)

2-FULL NAME John A. Fennemans

(a) RESIDENCE No. 1423 W. Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery Store

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant: Hospital Records

(Address) [illegible]

15 Filed 19 Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1923, to Feb. 16, 1923, that I last saw he alive on Feb. 16, 1923, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Chronic Hypertension.

Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of — —

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms & Signs.

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MOUNT CLIVET CEMETRY

DATE OF BURIAL: 2/20 19 23

20 UNDERTAKER: ROBERT BROCKSON

ADDRESS COR CALHOUN HOLLINS ST

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

D72713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D72713

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2311 Garrison Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ellen R. Woodland.

(a) RESIDENCE. NO. 2311 Garrison Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel H Woodland

6 DATE OF BIRTH (month, day, and year) Nov 15 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Dr Edw R. Burkhalter

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Lucy P Gillingham

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Samuel H Woodland (Address) 2311 Garrison Ave

Filed FEB 20 1923

ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1923, to Feb 18, 1923.

that I last saw h alive on Feb 18, 1923.

and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Earl Bowden, M. D.

2/19, 1923 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Feb 20 1923

20 UNDERTAKER John O. Mitchell

ADDRESS 820 W Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D72714

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D72714

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cor Forrest & Chase St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M Dermott

(Residence in Baltimore: No. Cor Forrest & Chase St.; 19 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, ... 10 (Month) ..... 15 (Day), 1900 (Year)

7-AGE,	If LESS than 1 day,
22 yrs. 4 mos. 3 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), New York

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother M Shaddens

(Address) St Agnes' Convent Chase St & Forrest Pl

15- FEB 20 1923 ROBERT R. KRAUTER, Registrar.

Filed....., 191..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 18 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1923, to Feb 1923, that I saw h[illegible] alive on Feb 13 1923, and that death occurred, on the date stated above, at 4.20 p.m.

The CAUSE OF DEATH* was as follows:

.....

..... Pulmonary Tuberculosis

..... (Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Mary F Vaughan M. D.

Feb. 18, 1923 (Address) 1028 N Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Cross Cem	Feb 20, 1923
20-UNDERTAKER	ADDRESS
Mark C Meade	Baltimore

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72715 D72715

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1228 Short alley ST., 5 WARD)

2-FULL NAME Earl Breeden

(a) RESIDENCE NO. 1228 Short ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 16 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year) Oct 30 1921

7 AGE — Years: — Months: 16 Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md. Md.

PARENTS

10 NAME OF FATHER: Mack Breeden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md,

12 MAIDEN NAME OF MOTHER: Austin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Flossie Breeden
(Address) 1228 Short alley

15 Filed FEB 20 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1923. to Feb. 17, 1923.

that I last saw h alive on Feb. 17, 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Gastric catarrh

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Robinson, M. D.

2/19/23 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Funeral Cemetery — DATE OF BURIAL: Feb 21 1923

20 UNDERTAKER: W. R. Robert - A. Elliott — ADDRESS 1725 Fleet

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72716

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1811 (Street) Maryland Ave (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Hutchinson

(a) RESIDENCE. No. 1811 Maryland Ave Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4 1922

7 AGE Years 11 Months Duys 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 1811 Maryland Ave Baltimore Md

PARENTS

10 NAME OF FATHER Jack Hutchinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Mamie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Sadie Hutchinson (Address) 1805 Maryland Ave

15 FEB 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1923, to Feb 15, 1923, that I last saw h[illegible] alive on Feb 15, 1923 and that death occurred on the date stated above, at 5 a.m. The CAUSE OF DEATH was as follows:

Lobar Pneumonia (Probably Tuberculosis)

Duration Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) P. Carlos Schmidt M. D.

(Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Feb. 19 1923

20 UNDERTAKER Joseph A. Gantt

ADDRESS 2319 Division

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D72717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D72717

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1814 Ashland Av ST., 7 WARD)

2-FULL NAME Janey Williams

(a) RESIDENCE No. 1814 Ashland Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6, 1838

7 AGE — Years: 84 — Months: — — Days: — — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Moses Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Annie Reynolds

(Address) 1814 Ashland Ave

15 Filed FEB 20 1923

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1923, to Feb. 17, 1923, that I last saw her alive on Feb. 17, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Interstitial nephritis

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of ...

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson, M. D.

2/19/23 (Address) 1520 E. Monument St

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery

DATE OF BURIAL: Feb 20 1923

UNDERTAKER: Mrs Robert F Elliott

ADDRESS: 1225 Eastland Ave

D72718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72718

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1007 Druid Hill Ave St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa M. Davis

(Residence in Baltimore: No. 1007 Druid Hill Ave, St.; yrs. 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): married

6-DATE OF BIRTH: August (Month) 15 (Day) 1867 (Year)

7-AGE: 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Jno. M. Seward

11-BIRTHPLACE OF FATHER, (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Fannie Jackson

13-BIRTHPLACE OF MOTHER, (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fannie Seward

(Address) 1007 Druid Hill Ave

FEB 20 1923

Filed 192

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb. (Month) 16, (Day) 192 (Year)

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) and Cirrhosis

(Duration) yrs. mos. ds.

(Signed) J. T. Henderson M. D. (Coroner.)

Feb. 19 192 (Address) 2502 Eutaw Pl.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn

DATE OF BURIAL: Feb 20 1923

20-UNDERTAKER: Jno. H. Todd

ADDRESS 42 W. Hill St.

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72719

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

D72719

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 Penn St ST., 4 WARD)

2-FULL NAME Joseph Oliver Garrett.

(a) RESIDENCE NO. 407 Penn St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life time mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Abbreviations not to be used. AGE should be stated EXACTLY. PHYSICIANS should state mode of dying.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Sept 5-1922

7 AGE — Years: | Months: 5 | Days: 13 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Alvin Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Stewart.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Alvin Garrett (Address): 407 Penn St

15 Filed FEB 20 1923, 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby-18 1923.

17

I HEREBY CERTIFY, That I attended deceased from Feby-15. 1923. to Feby-18. 1923. that I last saw him alive on Feby-17. 1923., and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary): Acute bronchitis (duration) yrs. mos. ✓ ds.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Fruhinger M. D. M. D.

2/18, 19 23 (Address) 622 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Feb 20 1923

20 UNDERTAKER: Jno N. Toadvine — ADDRESS: 172 [illegible]

Spec.—1-10-21—M&T—1500 Blks.

D72720 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 101-001 D72720

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St., WARD)

2-FULL NAME Fletcher Jones.

(a) RESIDENCE NO. 887 North Side Sparrows Pt. St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
23	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Works

9 BIRTHPLACE (city or town) Va

(State or country)

PARENTS

10 NAME OF FATHER Willie Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Alice Chesterfield

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

14 Informant Hutcherson Jones

(Address) 887 North Side Sparrows Pt. Md

15 Filed FEB 20 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1923, to Feb 18, 1923, that I last saw h— alive on Feb 18, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Sparrows Pt Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical.

(Signed) Harry F. Brown, M. D.

Feb 19, 1923 (Address) 1550 Pressman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dennuston, Va	Feb 20 1923
20 UNDERTAKER Halifax Co.	ADDRESS 142
pro N. Tolladine	Uxbell St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

Gross

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72721

CERTIFICATE OF DEATH.

101-001 D72721

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 S Eutaw ST., 21 WARD)

2-FULL NAME Benjamin Gross

(a) RESIDENCE NO. 814 S Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) American

(c) Name of employer Label Works

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bessie Hussey

(Address) 814 S. Eutaw St

15 Filed FEB 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1923, to Feb 17, 1923.

that I last saw him alive on Feb 17, 1923.

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

, 19 (Address) 714 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Feb 20 1923

20 UNDERTAKER Jno. H. Toadvin ADDRESS 142 Exeter St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72722

D72722

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. Guilford Ave & 21st St.: 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ara Howland Cullum

(a) RESIDENCE. No. Home for Incurables ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Cullum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Gay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Valiant

(Address) 426 Sumnan Ave Springfield Mass

15 FEB 20 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 17th, 1923, to Feb 18th, 1923, that I last saw her alive on Feb 18th, 1923, and that death occurred, on the date stated above, at 8:20 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Senility. Arteriosclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & symptoms

(Signed) J A Holland, M. D.

Feb 19th 1923 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Feb 20 1923

20 UNDERTAKER H E Hughes ADDRESS 424 N. Eden Way

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72723

HEALTH DEPARTMENT—CITY OF BALTIMORE

126 D72723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 545 W. Barre ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Harrell jr

(a) RESIDENCE. No. 545 W. Barre ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE — Years: 9 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): Loafer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phila, Pa.

10 NAME OF FATHER: Chas. Harrell Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Sallie Whitehurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

PARENTS

11 Informant: Bruce Spence

(Address) 545 W Barre St

15 Filed FEB 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/16/1923

17 I HEREBY CERTIFY, That I attended deceased from 2/10/1923 to 2/16/1923 that I last saw him alive on 2/16/1923 and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Unknown (Possibly Infection) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

2/17/1923 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Feb 20 1923
20 UNDERTAKER	ADDRESS
Edward Bryan	1631 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72724 CERTIFICATE OF DEATH. 74-001 D72724

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2228 Harrison ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretha Kranz

(a) RESIDENCE NO. 2228 Harrison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: August Kranz

6 DATE OF BIRTH (month, day, and year): July 28 1840

7 AGE: Years 82 Months 7 Days 23 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Casper Eberle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: August Kranz (Address) 2228 Harrison ave

15 Filed FEB 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15th, 1923, to Feb 17th, 1923, that I last saw h[illegible] alive on Feb 16th, 1923, and that death occurred, on the date stated above, at 2.35 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Cardiac Arteriosclerosis Paralysis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Herbert E. [illegible], M. D.

Feb 19, 1923. (Address) 20 E. N. Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmanuel Lutheran Zanesville DATE OF BURIAL 2/20/1923

20 UNDERTAKER: Geo. Weber & Son ADDRESS 2503 Edmondson ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Name should be stated EXACTLY. Abbreviations not to be used. Ages must be supplied.

Spec.—1-10-21—M&T—1500 Bks.

D72725

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72725

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 903 North Monroe ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Watts

(a) RESIDENCE NO. 903 North Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Widow of the late Wm J. Watts

6 DATE OF BIRTH (month, day, and year): May 14th 1858

7 AGE: Years 64 Months 9 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Hackett Chainey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Friend (Mrs Meiser

(Address) 5150 Reisterstown Road

15 Filed FEB 20 1923 ROBERT R. KRAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 18th 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 11, 1923, to Feb 18, 1923,

that I last saw her alive on Feb 18, 1923,

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? By Evans - Howard County

(Signed) [illegible], M. D.

, 19 (Address) 3713 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western cemetery

DATE OF BURIAL 2/21 1923

20 UNDERTAKER: Geo. Weber & Son

ADDRESS 2503 Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D72726

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72726

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 24 WARD)

2-FULL NAME Sarah Spencer

(a) RESIDENCE NO. 1247 Haubert St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ppp

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records

(Address)

Dec 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from February 17, 1923, to February 19, 1923, that I last saw her alive on February 19, 1923, and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Brot Faileure from
Chronic myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

2-19 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 2/22 1923

20 UNDERTAKER Wm Cook

ADDRESS 501 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72727

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D72727

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST.. 14 WARD)

2-FULL NAME Miss Fannie C Clarke

(a) RESIDENCE NO. 1702 W Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or Divorced, ~~(write the word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph H Clarke

6 DATE OF BIRTH (month, day, and year): About

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md Baltimore

PARENTS

10 NAME OF FATHER: Joseph H Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Jane Mudd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Miss Emma C Pinch

(Address) 831 Park Ave

Filed FEB 20 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/19/ 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1923. to Feb 19, 1923.

that I last saw h~~e~~r alive on Feb 19, 1923.

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac Failure Pulmonary Edema

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) W C Caldwell M. D.

, 19 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 22 19 23
20 UNDERTAKER	ADDRESS
William Lad	502 S Paca

D72728

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

22 100-001

D72728

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 116 W. Lee Street. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Brocato. ------ 5 -- 29.

(Residence in Baltimore: No. 116 W. Lee Street. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Single.

6-DATE OF BIRTH. August 20, 1922.
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
---- yrs. 5 mos. 29 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Vincent Brocato.

11-BIRTHPLACE OF FATHER. (State or Country). Italy.

12-MAIDEN NAME OF MOTHER. Mary Cascio.

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Brocato. (mother).

(Address) 116 W. Lee Street.

15- FEB 20 1923 Filed 192 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 18, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia.
Unknown.
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Eclampsia.
(Duration) yrs. mos. ds.

(Signed) Otto M. Bernhard M. D.
(Coroner)
Feb. 18, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cemetery. DATE OF BURIAL. Feb. 20 1923.

20-UNDERTAKER. James Dignan & Son ADDRESS 1000 S. Paca St

May be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D72729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72729

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1 Mercy Hospital St., 15 32 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Airey

(a) Residence No. 1525 N. Gilmor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 20 1922

7-AGE. 4 yrs. mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Hiram Airey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Elizabeth Monahan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

11- (Informant) Elizabeth Airey

(Address) 1525 N. Gilmor St.

FEB 20 1923 Filed 192

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 19 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb. 11th 1923 to Feb. 19 1923

that I last saw h.. alive on Feb. 19th 1923

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

(a) Tuberculosis Meningitis

(Duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) [illegible] M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL, Feb 21 1923

20-UNDERTAKER. R. H. Lewis ADDRESS 2226 Edmondson

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72730

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72730

CERTIFICATE OF DEATH.

159-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 Berry ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L Kercheville

(a) RESIDENCE NO. 810 Berry St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9 1923

7 AGE — Years — Months — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John J Kercheville

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Viola M Rooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John J Kercheville 810 Berry St

FEB 20 1923, 19

ROBERT N. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-9, 1923, to 2-19, 1923

that I last saw him alive on 2-19, 1923

and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

Patent Ductus Arteriosus

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, Acute

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs

(Signed) C J Kercheval, M. D.

2-20, 19 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Feb. 20 1923

20 UNDERTAKER: Chenowith Son — ADDRESS: Chestnut ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. ABC should be stated EXACTLY. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

D72731

CERTIFICATE OF DEATH.

D72731

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3428 Seney ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Virginia Callis

(a) RESIDENCE. NO. 3428 Seney ST. 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): 2-16-23

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer): Old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: James Callis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): James Callis Baltimore

15 Filed FEB 20 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-19 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-16 1923, to 2-19 1923, that I last saw her alive on 2-18 1923, and that death occurred, on the date stated above, at 8 15 m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Premature birth

(duration) yrs. 19 mos. ds.

18 Where was disease contracted - If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Sign

(Signed) C. O. Cuthbert M. D.

(Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: Feb 20 1923

20 UNDERTAKER: Chenoweth Son Chestnut Ave — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72732

CERTIFICATE OF DEATH.

74-001 ✓ D72732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 S. High St. ST., 3 WARD)

2-FULL NAME Catherine Th. Langan

(a) RESIDENCE No. 118 S. High St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 25-1885

7 AGE — Years: 38 — Months: — — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: James Langan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Jennie Feeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Cecelia Langan

(Address) 118 S. High St

15 FEB 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from ~~Feb~~ 15, 1923, to Feb 18, 1923,

that I last saw ~~her~~ alive on Feb 18, 1923,

and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Grippe

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Wenker, M. D.

7/17, 1923 (Address) 414 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 2/21 1923

20 UNDERTAKER: Chas. P. Evans & Son — ADDRESS: 11 W Mt Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72733

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72733

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 5 9 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. Perry

(Residence in Baltimore: No. 265 Colvin St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	black	single

6-DATE OF BIRTH. Aug. (Month) 9 (Day) 1922 (Year)

7-AGE. yrs. 7 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Chas. Perry

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Perry

(Address) 265 Colvin

15- Filed FEB 20 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb. (Month) 17/23 (Day) 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pertussis

(Duration) yrs. mos. ds.

(Signed) J. S. [illegible] M. D. (Coroner.)

2/19/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Nat. Zion Cem.	Feb. 25th 192[illegible]
20-UNDERTAKER.	ADDRESS
Wm J. G. Locke	1302 Jefferson St

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72734

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72734

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 817 Sterling St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Wilson

(Residence in Baltimore: No. 817 Sterling St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	black	

6-DATE OF BIRTH. Jan. 15/23, 1..... (Month) (Day) (Year)

7-AGE. ....yrs. 1 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Coleman Wilson

11-BIRTHPLACE OF FATHER, (State or Country). N. Carolina

12-MAIDEN NAME OF MOTHER. Mary Wilson

13-BIRTHPLACE OF MOTHER, (State or Country). N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Wilson

(Address) 817 Sterling

15-

FEB 20 1923

Registrar.

ROBERT N. KRAUTER,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb. 19/23, 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritus

.....(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Probably Intussusception

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Fuller M. D. (Coroner.)

2/20/23 192... (Address) 508 E. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Laurel — DATE OF BURIAL. Feb. 20. 1923

20-UNDERTAKER. Mrs. J. G. Locke — ADDRESS 1122 Jefferson St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72735 162 D72735

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 685 Josephine ST., 4 WARD)

2-FULL NAME Baby Malcomb

(a) RESIDENCE NO. 685 Josephine ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): ~~White~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-18-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Julius Malcomb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mabel Caughbree

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Julius Malcomb
(Address) same

15 FEB 20 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-19 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-18, 23, to 2-19, 1923

that I last saw him alive on 2-19-23, 19 ....

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No Clinical findings

What test confirmed diagnosis? .....

(Signed) J. Norwood Wilson M. D.

, 19 (Address) University & Hospital

*State the Disease Causing Death, or in deaths due to violent causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 2-20 19-23

20 UNDERTAKER David Easton

ADDRESS 916 Ca ave

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72736

CERTIFICATE OF DEATH.

32

D72736

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. Mercy Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Smith

(a) Residence No. 626 N. Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 20 1858

7-AGE. 64 yrs. 9 mos. 11 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) L. E. Jones 179

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Mary Land

PARENTS.

10-NAME OF FATHER, Hugh Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Sarah Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Geo Hoffe

(Address) 210 Penna Ave

15- FEB 20 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb 18 1923

17- I HEREBY CERTIFY That I attended deceased from Feb. 6 1923 to Feb 18 1923

that I last saw h[im] alive on Feb 18 1923

and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows: Tuberculous Peritonitis

" Meningitis

(Duration) 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Tox. & Autopsy findings

(Signed) J. J. Scruggs M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Balt Cemetery	Feb 20th 1923

20-UNDERTAKER,	ADDRESS
Geo Lemmlein & Son	6 W Pratt St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Physicians should state CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72737

CERTIFICATE OF DEATH.

90 D72737

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Pottier

(a) RESIDENCE NO. 633 Ensor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 1904

7 AGE: Years 19 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Barel Pottier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unno —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address): 1437 E Balto

15 FEB 20 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Assistant

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1923, to Feb. 20, 1923, that I last saw h.. alive on Feb. 20, 1923, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Chr. endocarditis & myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Isidore I. Jury, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Wash Rd

DATE OF BURIAL: 2/20 1923

20 UNDERTAKER: Jack Lewis

ADDRESS: 1437 E Balto

Spec.—1-10-21—M&T—1500 Bks.

16 D 2738 Feb 738

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72738

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ~~4 Piedmont~~ ST., 27 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Marie Cunningham

(a) RESIDENCE No. 4 N. Piedmont Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 6-1919

7 AGE — Years: 4 Months: Days: 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret B. Grass

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 Filed FEB 20 1923, 19 ROBERT R. KRAUTER, Registrar ~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1923, to Feb 18, 1923, that I last saw her alive on Feb 18, 1923 and that death occurred, on the date stated above, at 10 10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis of Nephrosis type

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. H. Mesch, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: 2/22 1923

20 UNDERTAKER: Philip Herring — ADDRESS: 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. ... AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D72739 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 D72739

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 Southern Ave ST., 16 WARD)

2-FULL NAME George Mehr

(a) RESIDENCE NO. 27 Southern av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 7 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lillian C. Mehr

6 DATE OF BIRTH (month, day, and year) June 25/57

7 AGE: Years 63 Months 7 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer) Cutter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Philip Mehr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lillian C. Mehr (Address) 27 Southern av

15 FEB 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1923, to Feb 18, 1923, that I last saw h[illegible] alive on Feb 17, 1923, and that death occurred, on the date stated above, at 10 15 A m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Abscess of Iliac Fossa

Erysipelas (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? by me

(Signed) Alan B Lemmon, M. D.

2/20/23 (Address) 714 N Patterson Pk av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk — DATE OF BURIAL 2/21 1923

20 UNDERTAKER Philip Hennig — ADDRESS 2016 Orleans

Spec.—1-10-21—M&T—1500 Bks.

D72740

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED No. D72740

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marrow Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Blackson

(a) RESIDENCE NO. 1622 McElderry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant Seaman

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Patients History

(Address)

15 Filed 19 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk

B 20192

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/19 1923

17

I HEREBY CERTIFY, That I attended deceased from 6-1, 1922, to 2-19, 1923,

that I last saw him alive on 2-19, 1923

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Valvular Disease, Chronic Cardiac.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) General Edema

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) P. E. Abrole M. D.

2/19 1923 (Address) Morrow Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemet

DATE OF BURIAL 2/20 1923

20 UNDERTAKER S. Levinson & Bro

ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72741

D72741

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 1620 McHenry St. ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Albert Kroneberger

(a) RESIDENCE. No. 1620 McHenry ST., WARD.

(Usual place of abode) about

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Anna Kroneberger

6 DATE OF BIRTH (month, day, and year) February 27, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	II	2I	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer) Toy Factory

(c) Name of Employer Baltimore Carriage & Toy Co.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Charles J. Kroneberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ------- Door

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Kroneberger

(Address) 1620 Mchenry St.

15 Filed FEB 20 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18 — 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 24, 1923 to Nov 17, 1923,

that I last saw him alive on Feb. 16, 1923,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Broncho Dilatation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Leaking valves &

(Signed) [illegible] M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 20, 23.

20 UNDERTAKER Harry N. Witzke ADDRESS 1531 W. Lombard St.

D72742

Treukamp ✓

11-002

D72742

Bloc. 4-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. D72742

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2442 Edmondson Ave ST., 16 WARD)

2-FULL NAME Mary B. Treukamp

(a) RESIDENCE NO. 2442 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): August Treukamp

6 DATE OF BIRTH (month, day, and year): Nov-8-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52.	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Peter Denges

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Dater

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. Frank Bowne

(Address) 2442 Edmondson ave

15 Filed FEB 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1923, to Feb. 18, 1923, that I last saw h alive on Feb. 17, 1923, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Meningitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical ex

(Signed) J. M. Lamphrier, M. D.

Feb 19 1923 (Address) 826 N Carrollton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 2-21 1923

20 UNDERTAKER: H. B Cunningham — ADDRESS 517 N Schroeder st

Spec.—1-16-21—M&T—1500 Bks.

Neary

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72743

CERTIFICATE OF DEATH.

100-001

D72743

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 W. 27th ST., 12 WARD)

2-FULL NAME Thos. Neary

(a) RESIDENCE NO. 201 W. 27th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13, 1922

7 AGE: Years | Months: 3 | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Thos. F. Neary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co.

12 MAIDEN NAME OF MOTHER: Edna May

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Thos F. Neary

(Address): 201 W 27th St

15 Filed FEB 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-19 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-17, 1923, to 2-19, 1923,

that I last saw h[illegible] alive on 2-19, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Primary)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

2/19 1923 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: Feb 20 1923

20 UNDERTAKER: H. C. Wiedefeld

ADDRESS: Greenmt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72744

CERTIFICATE OF DEATH.

91-002 D72744

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Hillman ST., 10 WARD)

2-FULL NAME Mary Mallon

(a) RESIDENCE NO. 1009 Hillman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Mallon

6 DATE OF BIRTH (month, day, and year): May 25-1870

7 AGE: Years 71 | Months 8 | Days 23 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of Industry, business, or establishment in which employed (or employer): Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anna Brylant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): John B. Mallon 915 E. Chase St.

15 Filed FEB 20 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-18 1923

17

I HEREBY CERTIFY, That I attended deceased from 2-9, 1923, to 2-18, 1923,

that I last saw h[e] alive on 2-18, 1923,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Bronchial asthma

(duration) ... yrs. mos 1 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Cirrhosis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of ...

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D W Edmonds M. D.

2/24, 1923 (Address) 914 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Hill — DATE OF BURIAL: 2-22 1923

20 UNDERTAKER: H. C. Wiedefeld — ADDRESS: 916 Greenmount

D72745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72745

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 717 N. Caroline St., 7 Ward)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Thompson

(Residence in Baltimore: No. 717 N. Caroline St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	black	Single

6-DATE OF BIRTH. Aug 16/23 1.....
(Month) (Day) (Year)

7-AGE. .....yrs. 6 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Nelson Thompson

11-BIRTHPLACE OF FATHER. (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Alma Coates

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Thompson

(Address) 717 N. Caroline

15-

Filed. FEB 20 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. FEB ~~20~~ 20/23 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primary bronchopneumonia

.....(Duration).....yrs.....mos. 3 ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) J. E. Collins M. D.
(Coroner)
2-20 1923 (Address) 506 6 Fountain

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt-Auburn Cemetery DATE OF BURIAL. Feb 20 1923

20-UNDERTAKER. Wm Robt A Elliott ADDRESS 1725 Aisquith St

THE CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D72746

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

100 D72746

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 647 E. 28 St. ST.: 9 WARD)

2-FULL NAME Agnus Hughes

(a) RESIDENCE. No. 647 E. 28 St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., if of foreign birth? 7/12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Nov 3 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER A. F. Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Grace Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Hughes

(Address) 647 E 28 St

15 Filed FEB 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1923, to Feb. 19, 1923, that I last saw h[illegible] alive on Feb. 19, 1923, and that death occurred, on the date stated above, at 3:40 P m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Lila Heimann, M. D.

, 19 (Address) 211 E. 25 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 19 1923
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 725 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Age should be stated EXACTLY. PHYSICIANS should state ... Every item of information ... spaces.

D72747

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72747

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 598 W. Preston St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. James E. Butler

(Residence in Baltimore: No. 598 W. Preston St.; yrs. 29 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH. (Month) Jan. (Day) 27 (Year) 1894

7-AGE. 28 yrs. 11 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: actor
(b) General nature of industry, business, or establishment in which employed (or employer): 0.0

9-BIRTHPLACE. (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: Jas. E. Butler

11-BIRTHPLACE OF FATHER. (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Rosie Cooley

13-BIRTHPLACE OF MOTHER. (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Rosie Butler

(Address) 598 W. Preston St.

15- FEB 20 1923 Filed ..... 192 .....

FEB 20 1923 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. (Month) Feb. (Day) 15 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fibroid Tuberculosis

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Anemia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Feb. 17 1923 (Address) 27 S. Eutaw St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt. Lebanon DATE OF BURIAL. 2/20 1923

20-UNDERTAKER. David Hensley ADDRESS 478 E. Eutaw St.

INSTRUCTIONS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D72748

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72748

100-001

CERTIFICATE OF DEATH.

5

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1162 Low St ST.: ..... WARD)

2-FULL NAME Dorothy Dorsey

(a) RESIDENCE. No. 1162 Low St ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 5 yrs ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	B	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1-6-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		13 mos.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Henry Starr

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible] Va.

12 MAIDEN NAME OF MOTHER Louise Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Louisa Starr

(Address) 1162 Low St

15 Date received FEB 20 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-19-1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 18, 1923, to Feby 18, 1923

that I last saw her alive on Feby 18, 1923

and that death occurred, on the date stated above, at 2, 30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical

(Signed) A. A. Hornstein, M. D.

2/20, 1923 (Address) 733 N. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 21 1923

20 UNDERTAKER Mrs Robert F Elliott ADDRESS 1725 Fiedland Ave

CAUSE OF DEATH in plain terms. ALL should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72749

CERTIFICATE OF DEATH.

100-001

D72749

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 W Hamburg ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Jackson

(a) RESIDENCE. NO. 226 W. Hamburg ST., 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 12 1922

7 AGE — Years: 1 — Months: — Days: 5 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Thos. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Henrietta Putney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mariella Green (Address) 226 W Hamburg St

15 Filed FEB 20 1923, 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/17/1923

17 I HEREBY CERTIFY, That I attended deceased from 2/15/23, 19 23, to 2/17/23, 19 23, that I last saw h alive on 2/17/23, 19 23, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Teething) (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dr. Corley, M. D.

2/17/23, 19 (Address) 908 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Feb 22 1923

20 UNDERTAKER: I L Brownson — ADDRESS: 1080 W Pratt

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D72750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D72750

REGISTERED NO.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state whether Attending, Consulting, or Autopsy surgeon. Every item of information should be supplied.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wesley Sales

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896 (?)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	27 (?)	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1923

17

I HEREBY CERTIFY, That I attended deceased from February 12, 1923 to February 16 1923.

that I last saw him alive on February 16, 1923.

and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Hydrothorax paracentesis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings P.E.

(Signed) Clyde A. Heck, M. D.

2-17-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Ct DATE OF BURIAL Feb 20 1923

20 UNDERTAKER J. L. Brown & Son ADDRESS 1081 W. Monty

Spec.—6-9-19—H. P. Co.—1900 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72751 D72751

CERTIFICATE OF DEATH.

REGISTERED No. 124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2174 W Biddle ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Coyson

(a) RESIDENCE. No. 2174 W Biddle ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fanny Coyson -

6 DATE OF BIRTH (month, day, and year) Sept. 15? 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, Gen'l

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown Feb 19, 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Julia Munroe (Address) 2174 Biddle

15 Filed FEB 20 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923, to Feb 18, 1923, that I last saw h— alive on Feb. 16, 1923, and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Uremia

(duration) yrs. 3? mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H. Wright, M. D.

(Address) 1209 Pressman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	2-20 1923
20 UNDERTAKER George H. Holland	ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D72752

HEALTH DEPARTMENT—CITY OF BALTIMORE

Kruszelicki 162 D72752

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 Grace Court ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Kruszelnicki

(Residence in Baltimore: No. 1415, Grace Court St.; ..yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb 19, 1923 (Month) (Day) (Year)

7-AGE, ..yrs. ..mos. ..ds.

If LESS than 1 day, ..hrs. or 20 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Walter Kruszelnicki

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Rosa Lopuszanska

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Kruszelnicki

(Address) 1415 Grace Court

15-

FEB 20 1923 Filed....., 191.....

ROBERT F. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 19, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 19 1923, to — 191 ,

that I saw h—alive on 191 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Asphyxia Monoxidum (Coal Gas)

..... (Duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..yrs. ..mos. ..ds.

(Signed) Leon L. Starka M. D.

Feb 20, 1923 (Address) Curtis Bay, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Cross

DATE OF BURIAL, 2/20, 1923

20-UNDERTAKER Wm F. Jackowski

ADDRESS 1118 Cookes

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72753

CERTIFICATE OF DEATH.

D72753

1 PLACE OF DEATH Southern Hospital Gremson St. 12 Ward

CITY OF BALTIMORE (No.)

REGISTERED No. C

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charlotte J. Hemmick

(Residence in Baltimore: No. Southern Hospital St., yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX. Female

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6 DATE OF BIRTH May (Month) 9 (Day), 1856 (Year)

7 AGE, 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer) Home

PARENTS

9 BIRTHPLACE (State or Country) Ellicott City Md.

10 NAME OF FATHER Hezekiah Hemmick

11 BIRTHPLACE OF FATHER (State or Country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Annah Hughes

13 BIRTHPLACE OF MOTHER (State or Country) Ellicott City Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. L. Smith

(Address) Southern Hospital

15

Filed ..... 191....

Robert F. Harrison,

Burial Permit Clerk.

Registrar.

201923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 19 (Month) (Day), 191 (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns

from Oil Stove

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner.)

191.... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, OR REMOVAL. London Park

DATE OF BURIAL Feb 20, 191..

20 UNDERTAKER George J. Smith

ADDRESS 1532 Pulaski

V. S. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEPARTMENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D72754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72754

CERTIFICATE OF DEATH.

100-500

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Burgess.

(a) RESIDENCE NO. 848 Pennsylvania alley ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1847

7 AGE: Years 76. Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital Balto, Md.

FEB 20 1923

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1923 to Feb. 16, 1923

that I last saw him alive on Feb. 15, 1923 at 6.00 p. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Terminal)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) N. E. Edmunds M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cemetery

DATE OF BURIAL: Feb 23 1923

20 UNDERTAKER: Geo. T. A. Gibson

ADDRESS: 413 Lawrence St.

D72755 HEALTH DEPARTMENT—CITY OF BALTIMORE D72755

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1508 Madison Ave St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Thomas Welch

(Residence in Baltimore: No. 1508 Madison Ave St.; 71 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single, Married, Or Divorced, (Write the word.)~~ Widowed

6-DATE OF BIRTH. — — 1852
(Month) (Day) (Year)

7-AGE. 71 yrs. — mos. — ds.

If LESS than 1 day, — hrs. or — min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer) House Work

9-BIRTHPLACE. (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER. George Earhardt

11-BIRTHPLACE OF FATHER. (State or Country) Va

12-MAIDEN NAME OF MOTHER. Elizabeth Leech

13-BIRTHPLACE OF MOTHER. (State or Country) Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Pauline Welch.

(Address) 1508 Madison Ave

15- Feb 20 1923 Robert P. Harrison, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb. 19 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis heart disease

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) no history

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. C. Hennessy M. D.
(Coroner.)

Feb 20, 1923 (Address) 2501 E Lanvale

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Pk. DATE OF BURIAL. Feb 22 1923

20-UNDERTAKER. Martin Bakey Son ADDRESS. 1827 N North Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8 20 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72756

99-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 212 N Montford ave ST.; (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Diggs

(a) RESIDENCE. No. 212 N Montford ave ST.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Diggs

6 DATE OF BIRTH (month, day, and year) 1828

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
95	Jan		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Catonsville Maryland

PARENTS

10 NAME OF FATHER William Beatty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Annie Kelly

(Address) 212 N Montford ave

15 Filed Feb 19 1923 Robert P. Harrison, Registrar

201923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 14, 1923, to Feby 19, 1923, that I last saw her alive on Feby 18, 1923, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General diagnosis

(Signed) Adolph C. Wiesenbert, M. D.

Feby 19 1923 (Address) 2201-03 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Feb 21 1923
20 UNDERTAKER	ADDRESS
Milton Davis	315 N Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... PHYSICIANS should state EXACTLY. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72757

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72757

CERTIFICATE OF DEATH

1-PLACE OF DEATH General German Aged People's Home REGISTERED NO. 161-00

CITY OF BALTIMORE: (No. N. E. Cor Balto Hanson St.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Kroner

(a) RESIDENCE No. N. E Cor Balto Hanson St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 7 mos. ds. How long in U. S., if of foreign birth? 51 yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 21 1839

7 AGE — Years: 83 — Months: 8 — Days: 29 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Görlitz Prussia

PARENTS

10 NAME OF FATHER: Ernest Aug. Friedrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Görlitz Prussia

12 MAIDEN NAME OF MOTHER: Henrietta Kirst

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Görlitz Prussia

14 Informant (Address): Records German Aged Home N E Cor Balto & Hanson

15 2 0 1923 Robert P. Harrison, Registrar

. 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 19 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/17/23 . 19 . to 2/19/23 . 19 23 .

that I last saw h[illegible] alive on 2/18/23 . 19 .

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John Hauff, M. D.

2/20 1923 (Address) 1843 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Feb 21 1923

20 UNDERTAKER: W B Cook

ADDRESS: 1003 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72758

CERTIFICATE OF DEATH.

90 D72758

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Tucker Ave. (ST.) Hillsdale, Md. (WARD) 28

2-FULL NAME Henrietta Doody

(a) RESIDENCE NO. Tucker Ave. (ST.) Hillsdale, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Doody

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
71	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Joseph Hook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sophia Spedden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant John Doody (Address) Hillsdale, Md.

15 Filed Feb 21 1923 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10th, 1923, to Feb. 18th, 1923, that I last saw her alive on Feb. 15th, 1923, and that death occurred, on the date stated above, at 12.15 Noon

The CAUSE OF DEATH* was as follows:

Chronic Arthritis

(duration) 3 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myo-Carditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Chas. H. Waters M. D.

2/19. 1923 (Address) City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Feb 20 1923

20 UNDERTAKER Joseph B Cox

ADDRESS 1003 N. Bond

$1

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72759

CERTIFICATE OF DEATH. 73

D72759

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Friendsbury St. ST., 15 WARD)

2-FULL NAME Georgiana Nolan

(a) RESIDENCE NO. 1617 Friendsbury St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state ... Every ... of information supplied.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Nolan

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71		Unknown	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles L. Spies

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mr. Geo. W. Carrick

(Address) 856 W. Baltimore St.

15 Filed 2/19 19 23 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18" 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 12 1922, to Feb 18 1923.

that I last saw h[illegible] alive on Feb 18 1923,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis.

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) Chronic diffuse nephritis

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J Sullivan M. D.

2/19 1923 Address 1701 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem.	Feb. 21 1923
20 UNDERTAKER: Chas. B. Cook	ADDRESS: 1003 N. Paca St.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72760

CERTIFICATE OF DEATH.

90 D72760

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1006 N. Payson St. ST., 16 WARD)

2-FULL NAME James H. L. Foote

(a) RESIDENCE NO. 1006 N. Payson St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Foote

6 DATE OF BIRTH (month, day, and year) Jan. 30th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74	0	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of Industry, business, or establishment in which employed (or employer) Bergners

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Harriet H. Spalding

(Address) 1006 N. Payson St.

15 2/19 1923 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 , 19 23 , to Feb 18 , 19 23 .

that I last saw h alive on Feb 18 , 19 23 .

and that death occurred, on the date stated above, at 9:40 m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Contributory (duration) yrs mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) Thos Fuller, M. D.

2/19 1923 (Address) 1001 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Feb 21st 1923

20 UNDERTAKER Joseph B. Cork

ADDRESS 1003 N. Bond St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

166-001 D72761

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 115 E. Virginia Ave ST., 27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah E. Dunn

(a) RESIDENCE NO. 115 E. Virginia ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard A. Dunn

6 DATE OF BIRTH (month, day, and year): Oct 4 1859

7 AGE — Years: 63 — Months: 4 — Days: 14 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: James Cooney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Ella Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Richard A. Dunn 115 E. Virginia ave

15 Filed 2 0 1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1923, to Feb 18, 1923, that I last saw h[illegible] alive on Feb 18, 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Edw J Nally M. D.

, 19 (Address) 2 W Biddle st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 2/21 1923

20 UNDERTAKER: Chas F. Evans & Son

ADDRESS: 1118 Mont. Royal ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state carefully supplied. Every item of information

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72762

CERTIFICATE OF DEATH.

7 117 D72762

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas B. Scruggs.

(Residence in Baltimore: No. Turners Station Md. St.; ....yrs., ...mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) —

6-DATE OF BIRTH, Dec. 14, 1891
(Month) (Day) (Year)

7-AGE, 32 yrs. 2 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter

9-BIRTHPLACE, (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, Robert Scruggs

11-BIRTHPLACE OF FATHER (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER Ida Ballard

13-BIRTHPLACE OF MOTHER (State or Country), South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie V. Scruggs

(Address) Turners Station

15-

Filed ....., 1923 Robert P. Harrison, Registrar.
By ..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 19, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 12 1923, to Feb. 19 1923, that I saw him alive on February 19 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

(Signed) James Hurst Wilkerson M. D.

Feb 19 1923 (Address) Turners Station Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 7 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Turners Station Md.

19-PLACE OF BURIAL OR REMOVAL, Norwood M. E.

DATE OF BURIAL, Feb. 22, 1923

20-UNDERTAKER Wm Cook

ADDRESS 558 E. 20th ave

DEATHS OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

D72763

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72763

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 58 Russell St., 25 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Caroline Handy

(Residence in Baltimore: No. 58 Russell St., 75 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ... 1838
(Month) (Day) (Year)

7-AGE. 85 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... at home

9-BIRTHPLACE. (State or Country). Balto City

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country), unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country) unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Bailey

(Address) 44 Russell st

15-

Filed ..... 192?

Robert P. Harrison,
Burial Permit Clerk.
Registrar.

20 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 17 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Hepburn M. D.
(Coroner.)

Feb 20 1923 (Address) 708 E Chase St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Feb 21 1923

20-UNDERTAKER.	ADDRESS
Bloom Tredant & Schnorbus	1148

state CAUSE OF DEATH in plain terms, so that is very important. See instructions on back of

...supplies. AGE should be stated EXACTLY. PHYSICIANS should ...that it may be properly classified. Exact statement of OCCUPATION ...ck of certificate.

D72764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72764

CERTIFICATE OF DEATH.

188-001

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Tunnel at St Paul & 26th Sts (Ward) 17

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm J. Bacon

(Residence in Baltimore: No. 212 E. 22nd St

St.) 55 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... Nov ....., 1866
(Month) (Day) (Year)

7-AGE, 56 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Ass't Rail Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) ..... B & O R R

9-BIRTHPLACE, (State or Country), England

PARENTS.

10-NAME OF FATHER, Thomas Bacon

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Martha Keating

13-BIRTHPLACE OF MOTHER (State or Country) England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine A. Bacon

(Address) 212 E. 22nd St

15- Dated ....., 191.... Robert P. Harrison
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb ....., 18, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

Bell. Chronic

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

2532 Rhode

1923 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral

DATE OF BURIAL, Feb. 21, 1923

20-UNDERTAKER William Lucas

ADDRESS 1826 Northern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

201923

Spec.—1-10-21—M&T—1500 Bks.

D72765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-002 D72765

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1917 W. Lafayette Ave. (Ward) 16

2-FULL NAME Mrs Alice Ann Hack

(a) RESIDENCE NO. 1917 W. Lafayette Ave. WARD Sixteenth

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Henry Clay Hack.

6 DATE OF BIRTH (month, day, and year) Dec. 11-1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	81	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac Co. Virginia

PARENTS

10 NAME OF FATHER John Walker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Co. Virginia

12 MAIDEN NAME OF MOTHER Mary Kellam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Accomac Co. Virginia

14 Informant Leslie C. Hanlon (Address) 1917 W. Lafayette ave

15 Filed ..... 19..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febry 19 1923.

17 I HEREBY CERTIFY, That I attended deceased from Febry 14 1923, to Febry 19 1923, that I last saw h[illegible] alive on Febry 18 1923, and that death occurred, on the date stated above, at 9.55p. m.

The CAUSE OF DEATH* was as follows:

Grippe

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) George C. Shannon, M. D.

2/19 1923 (Address) 700 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park. DATE OF BURIAL Febr 21 1923

20 UNDERTAKER Wm J. Tuckner Sons ADDRESS N. Y. Pa.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72766 HEALTH DEPARTMENT—CITY OF BALTIMORE D72766

CERTIFICATE OF DEATH. 107-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Arlene Gressitt.

(a) RESIDENCE NO. 2009 Granby ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married-

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Gressitt.

6 DATE OF BIRTH (month, day, and year): July 20. 1891

7 AGE: Years 31 Months 7 Days ✓ If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland-

PARENTS

10 NAME OF FATHER: Gordon Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary R. Dorn[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hospital Records.

(Address)

15 Filed , 19 Robert F. Harris[illegible]

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 19 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 17, 1923, to Feb 19, 1923,

that I last saw her alive on Feb 19, 1923,

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Abcess of lung.

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary): Staphylococcus Septicemia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home-

Did an operation precede death? yes Date of Feb 13, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Operation + Laboratory

(Signed) Ky. Gosaley, M. D.

Feb 19, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bonaparte

DATE OF BURIAL: Feb 24 1923

20 UNDERTAKER: Wm. J. Finney Sons

ADDRESS: No. [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Should always be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should State

D72767 HEALTH DEPARTMENT—CITY OF BALTIMORE D72767

177

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Leilach Mc Kinsey

(Residence in Baltimore: No. 3401 Holmes Ave St.; yrs., 10 mos. ds.)

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Nov. (Month) 30 (Day) 1891 (Year)

7-AGE, 31 yrs. 2 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Journalist
(b) General nature of industry, business, or establishment in which employed (or employer) Sun Paper

9-BIRTHPLACE, (State or Country) Frederick Md.

PARENTS.

10-NAME OF FATHER, Folger Mc Kinsey

11-BIRTHPLACE OF FATHER, (State or Country), Elkton Md.

12-MAIDEN NAME OF MOTHER, Fannie N. Duryea

13-BIRTHPLACE OF MOTHER, (State or Country), Phila. Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Duncan Mc Kinsey

(Address) 3401 Holmes Ave

15-

Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

2 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb. (Month) 20 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Nephritis.

1

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Tab. Hg Cl 2 - Accident

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo Clinton Bladel M. D.
(Coroner)

Feb 23 192.. (Address) 1436 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Robinsons Ha. A.A. Co. Md. DATE OF BURIAL, Feb. 22 1923

20-UNDERTAKER, W. J. Tickner & Sons ADDRESS North & Penna Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72768 D72768

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: No. St Joseph's Hosp ST. 1 WARD

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Mielke

(a) RESIDENCE. No. 11 S. Polonac ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state

FEB 20 1923

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caspar Mielke

6 DATE OF BIRTH (month, day, and year) June - 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Louis Tiburtius

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Rauh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Caspar Mielke

(Address) 11 S. Polonac St

15 Filed FEB 20 1923 Robert P. Harrison, Registrar

Chief Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1923. to Feb. 17, 1923.

that I last saw her alive on Feb. 17, 1923

and that death occurred, on the date stated above, at 7.25 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? C. S. & S.

(Signed) John J. Kiagin, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	2/21 1923
20 UNDERTAKER J. G. Moran	ADDRESS 2222 E Baltimore

D.72769

STATE OF MARYLAND
CERTIFICATE OF DEATH

D72769 99-662

1 PLACE OF DEATH D72769
City or County of Baltimore

Registration Dist. No. 16

Village or City Baltimore (No. 4014, Edmondson Ave St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Margaret Cecilia Walsh

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Fe	White	Single

6 DATE OF BIRTH: Feb 4, 1869 (Month) (Day) (Year)

7 AGE: 54 yrs. 0 mos. 15 ds. If LESS than 1 day ... hrs. or ... min. ?

8 OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed or (employer):

8 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Patrick Walsh

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary King

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Walsh

(Address) 4014 Edmondson Ave

15 FEB 20 1923 192 ROBERT F. [illegible] Registrar

Burial Permit Clerk.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb 18, 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1917, to Feb 18, 1923,
that I last saw h[illegible] alive on Feb 18, 1923,
and that death occurred on the date stated above, at 3.40 p.m.

The CAUSE OF DEATH * was as follows:

Chronic Bronchitis, Asthma

(Duration) 13 yrs. — mos. — ds.

Contributory Secondary: Bronchitis, Hypostatic Congestion of Lungs.

(Duration) ... yrs. ... mos. 12 ds.

(Signed) C. L. Mayfield M. D.

Feb 19 1923 (Address) Edmondson Ave Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... da. In the State, ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Feb 21, 1923

20 UNDERTAKER	ADDRESS
John Moran	[illegible]

Spec.—1-10-21—M&T—1500 Bks.

D72770

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 D72770

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 Pear Alley ST. 17 WARD)

2-FULL NAME Annie Boston

(a) RESIDENCE NO. 910 Pear Alley ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Harry Boston

6 DATE OF BIRTH (month, day, and year) — — 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Daniel Easton

(Address) 916 Pear Alley

15 FEB 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14 1923 to Feb. 17 1923

that I last saw h[illegible] alive on Feb. 17 1923

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(duration) ..... yrs. ..... mos. 11 ds.

18 Where was disease contracted if not at place of death? At Home 7 Last

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

2/20, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 2-21-1923

20 UNDERTAKER David Easton

ADDRESS 916 Pear

BURIAL PERMIT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72771 | 101-00 | D72771

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2137 Pulaski St. 15 WARD

2-FULL NAME Grace Mc Dermott

(a) RESIDENCE. No. 2137 Pulaski St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. PHYSICIANS should state item of information which is not known.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Mc Dermott

6 DATE OF BIRTH (month, day, and year): June 11-1881

7 AGE: Years 41 | Months 8 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at home

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John W. Mc Donald

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wash D.C.

12 MAIDEN NAME OF MOTHER: Margaret Easly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wash D.C.

11 Informant (Address): John W. Mc Donald 2137 Pulaski St

15 Filed FEB 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 18 1923 to Feb 19 1923.

that I last saw h[illegible] alive on Feb 19 1923

and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) F. C. Link M. D.

1923 (Address) 1813 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Feb 21 1923

20 UNDERTAKER: Josiah Lyder — ADDRESS: 1600 W North Ave

D72772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-601 D

REGISTE

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Joseph's Hosp ST.: 70 WARD)

2-FULL NAME Baby Watkins

(a) RESIDENCE. NO. 197 N Catherine ST., WARD.
(Usual place of abode) (If nonresident give

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 19, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Alice Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jennie Freeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Alice Watkins (Address) 197 N Catherine St

15 Filed FEB 2 1923 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 19 23

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 19 23 to Feb. 20, 19 23

that I last saw h alive on Feb. 20, 19 23

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

7 mo. Congenital Toxins

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H M Freeman, M. D.

, 19 (Address) 2631 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leaving Cedar Grove, Mt Airy

DATE OF BURIAL Feb 21 19

20 UNDERTAKER Wm Cook

ADDRESS 502 E Fayette

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic meningitis"); *Diphtheria*; *Typhoid fever* (never re-ia"); *Lobar pneumonia*: umonia," unqualified, is *of lungs, meninges, peri-arcoma*, etc., of.....finite; avoid use of blasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cremation Burial
Influenza in
Mother.

D72773

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 D72773

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 McHenry ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Bukacevich

(Residence in Baltimore: No. 1316 Mc Henry st St.; 9 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

6-DATE OF BIRTH: December 15 1905 (Month) (Day) (Year)

7-AGE: 17 yrs. 2 mos. 4 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country): Serbia

PARENTS

10-NAME OF FATHER: Thomas Ciroglovitz

11-BIRTHPLACE OF FATHER (State or country): Serbia

12-MAIDEN NAME OF MOTHER: Wanda Alaber

13-BIRTHPLACE OF MOTHER (State or country): Serbia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Bukacevich

(Address) 1316 McHenry St

15-

Filed FEB 21 1923

ROBERT N. KRAUTER, Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Febry 19, 1923 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Febry 11, 1923, to Feb 18 1923, that I saw her alive on Feb 18 1923, and that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs 6 mos. ds.

Contributory (SECONDARY) ?

(Duration) yrs. mos. ds.

(Signed) Samuel Silverstein M. D.

Feb 20, 1923 [Address] 22 S. Broadway

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: Feb 21 1923

20-UNDERTAKER: A. Jones

ADDRESS: 111 S. Gilmor St

Spec.—1-10-21—M&T—1500 Bks.

Thornton Le Grand De Mars

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72774

CERTIFICATE OF DEATH.

109-002 D72774

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 N. Eutaw St. ST., 16 WARD)

2-FULL NAME Thornton Le Grand De Mars

(a) RESIDENCE NO. 914 N. Eutaw St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2-1915

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
8	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thos. E. De Mars

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wyoming U.S.A.

12 MAIDEN NAME OF MOTHER: Mary Irwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wyoming

14 Informant: Thos. E. De Mars
(Address) 914 N. Eutaw St.

15 Filed DEC 21 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 1923, to Dec 19 1923, that I last saw him alive on Dec 18 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Ludwig's Angina

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. Carter, M. D.

Dec 20, 1923 (Address) 111 W. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Not yet determined

DATE OF BURIAL: Dec 21 1923

20 UNDERTAKER: Returned to

ADDRESS

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY WITH PEN AND INK

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72775

CERTIFICATE OF DEATH.

90 D72775

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1545 N. Fulton Ave ST., 15 WARD)

2-FULL NAME Elizabeth B. Driscoll

(a) RESIDENCE No. 1545 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Driscoll

6 DATE OF BIRTH (month, day, and year) Feb 14th, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	-	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Birmingham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER ---- Brannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant James J. Driscoll

(Address) 1545 N. Fulton Ave

15 Filed FEB 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9th, 1923, to Feb 19th, 1923 that I last saw h[illegible] alive on Feb 19th 1923, 11:30 P m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion of the Lungs (duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J Sullivan M. D.

Feb 20, 1923 (Address) 1706 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Feb 22, 1923

20 UNDERTAKER Putnam Moore

ADDRESS [illegible]

Gustav A Anderson

HEALTH DEPARTMENT--CITY OF BALTIMORE

D72776
1 PLACE OF DEATH

CERTIFICATE OF DEATH

91-002 D72776
REGISTERED NO. C

CITY OF BALTIMORE (No. 251 Prospect Ave. ST.: 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME G.A.Anderson

(Residence in Baltimore: No. 251 Prispect Ave. St.: 10 yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED (Write the word)
male	white	married

6-DATE OF BIRTH: July (Month) 29 (Day), 1859 (Year)

7-AGE: 63 yrs. 6 mos. 22 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer): Fire Apparatus

9-BIRTHPLACE (State or country): Sweden

PARENTS

10-NAME OF FATHER: Abraham Anderson

11-BIRTHPLACE OF FATHER (State or country): Sweden

12-MAIDEN NAME OF MOTHER: Gustavia Billman

13-BIRTHPLACE OF MOTHER (State or country): Sweden

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. G.A.Anderson

(Address) 251 Prospect Ave.

FEB 21 1923 Filed ....., 191 ROBERT F. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Feb.20/23 (Month) (Day), 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 10/20, 191, to Feb.18/23, 191, that I saw him alive on Feb. 18/23, 191, and that death occurred, on the date stated above, at 9 AM m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

(Duration) 4 yrs. mos. ds

Contributory (SECONDARY) Undetermined (Duration) yrs. mos. ds.

(Signed) J S H Pollitt M. D.

2-21, 1923 (Address) 508 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Druid Ridge Cemetery | DATE OF BURIAL: Feb. 22, 1923

20-UNDERTAKER: A.S. Marshall | ADDRESS: 3539 Falls Rd

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72777

CERTIFICATE OF DEATH.

14-001

D72777
REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2443 Elling St ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Jones Spencer

(a) RESIDENCE No. 2443 Elling St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Spencer

6 DATE OF BIRTH (month, day, and year) 1868 Jan

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Dorsey Jones

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Cecilia Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mr Dorsey Jones
(Address) 2443 Elling St

15 Filed FEB 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk
19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5th, 1922, to Feb 20th, 1923, that I last saw her alive on Feb 18th, 1923, and that death occurred, on the date stated above, at 4.45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage with left sided hemiplegia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) none known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) Chas. J. Keller M. D.

, 19 (Address) 222 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Auburn Feb 22nd 1923

20 UNDERTAKER — ADDRESS

Samuel Elbert 1364 Ca

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72778 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 ✓ D72778

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 558 St. Mary ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Stewart

(a) RESIDENCE NO. 558 St. Mary ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Agar Stewart

6 DATE OF BIRTH (month, day, and year): July 7th 1901

7 AGE: Years 21 Months 7 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Phoebe Pole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bridgeville Del.

14 Informant: James Robinson

(Address) 558 St Mary

15 FEB 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 18, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1923, to Feby 18, 1923, that I last saw her alive on Feby 18, 1923, and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Sputum

(Signed) W. F. Mobilla M.D.

2/24 1923 (Address) 1191 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 2 27 1923

20 UNDERTAKER: Sam'l Hemsley

ADDRESS 778 N Gilmor St

Duration should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D72779

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1522 Argyle Av ST. 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katie Addison

(Residence in Baltimore: No. 1522 Argyle Ave. St.; yrs., mos. ds.) 57

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widow

6-DATE OF BIRTH, about ....., 187.. (Month) (Day) (Year)

7-AGE, 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Rosa Richardson

(Address) 1159 Druid Hill Av.

15- Feb. 21 1923, 191.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb. 18, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

Feb. 21, 1923 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, 2/22 ....., 1923

20-UNDERTAKER Frank D Hemsley ADDRESS 538 N Bdde St

Item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D72780

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

153 D72780

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 27 WARD)

2-FULL NAME Veredele L. Flemming

(a) RESIDENCE NO. 418 Wilson Terrace (Garrison) ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	23	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. G. Flemming

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Sarah Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 21 1923, 19 Burial Permit Issued. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 19 23

17

I HEREBY CERTIFY, That I attended deceased from Feb. 13, 19 23. to February 18 19 23.

that I last saw him alive on February 18, 19 23,

and that death occurred, on the date stated above, at 10:45 A. M.

The CAUSE OF DEATH* was as follows:

Cellulitis of left side of neck

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) abscessed tooth

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? Yes Date of 2-10/23

Was there an autopsy? Yes

What test confirmed diagnosis? Examination.

(Signed) Otto H. Neill, M. D.

2-19-19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Feb 21 1923

20 UNDERTAKER Sam'l N. Chase

ADDRESS 1400 Mosher

Nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72781

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 622 Brent St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith

(a) RESIDENCE. No. 622 Brent St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Smith

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE Years 50 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

040

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Henry Clark

(Address) Owings Mills Md

15 Filed FEB 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1923, to Feb 19, 1923, that I last saw h— alive on Feb 19 1923 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Contributory

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R. Carlos Schmidt M. D.

Feb 19 1923 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Pleasant Cemetery	Feb 21 1923
20 UNDERTAKER Butler & Sons	ADDRESS Reisterstown Md
J. F. Elmie	

FILL OUT CAREFULLY. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72782

CERTIFICATE OF DEATH.

101-001

D72782

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ridgely ST., 1 WARD)

2-FULL NAME Frances Ann Cook

(a) RESIDENCE NO. Ridgely St. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE — Years: about 65 years; Months: ; Days: ; If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper D37

(b) General nature of Industry, business, or establishment in which employed (or employer): House work D37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Essex Co. Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Hattie Pye
(Address) Pikesville & Catonsville

15 FEB 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9th, 1923, to Feb 19th, 1923, that I last saw her alive on Feb 19th, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D H Connell, M. D.

2/21, 1923 (Address) 1 Cowhill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: Feb 21 1923

20 UNDERTAKER: D.R.R. Robert & Elliott Richmond — ADDRESS 125

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72783

CERTIFICATE OF DEATH.

D72783

162

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Modray

(Residence in Baltimore: No. 135 W. Lee St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
male	white	single

6-DATE OF BIRTH. Feb 8/23 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
yrs. mos. 4 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Robert Modray

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Ethel ------

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hospital

(Address)

15- Filed FEB 2 1923 JOHN S. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 12/23, 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fibrinous Peritonitis

Infection from umbilical cord

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J S H Voris M. D. (Coroner.)

2-16 1923 (Address) 508 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. JOHNS HOPKINS HOSPITAL DATE OF BURIAL. 19

20-UNDERTAKER. Health Commissioner of Health, ADDRESS FEB 20 1923

State CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should properly classified. Exact statement of OCCUPATION

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72784

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

100-00 D72784

Registered No. C.....

City of BALTIMORE: (No. 1522 Pennsylvania St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... William Maddy .....

(Residence in Baltimore: No. 1522 Pennsylvania St.; 2 yrs. 1 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	single

6-DATE OF BIRTH. ..... Jan. 10, ... 1921
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
2 yrs. 1 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm. Maddy

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Bernice Brooks

13-BIRTHPLACE OF MOTHER, (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernice Maddy .....

(Address) 1522 Pennsylvania Ave

15-

Filed FEB 2 1923 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb. 19, ... 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Bronchio-Pneumonia .....

..... (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) ..... Measles History .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... J. T. Hennessy ..... M. D.
(Coroner.)

Feb. 20 1923 (Address) 202 Hamburg St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Feb 21 1923

20-UNDERTAKER,	ADDRESS
James N. Lewis	1213 Druid Hill Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

D72785 HEALTH DEPARTMENT—CITY OF BALTIMORE D72785

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Segal

(a) RESIDENCE NO. 706 S. Charles st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O'K'D

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Segal

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rena Eddis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 FEB 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1923, to Feb. 18, 1923,

that I last saw him alive on Feb. 18, 1923,

and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum,

(Signed) Francis L. Dalaglacca M. D.

2-19-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peter's Cemetery

DATE OF BURIAL Feb 21 1923

20 UNDERTAKER Wm. Hirsch & Son

ADDRESS 1737 N Rutter

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72786

D72786

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 N. Fenttle. St. 7th WARD)

2-FULL NAME Edward Joseph Winkler.

(a) RESIDENCE NO. 119 N. Fenttle ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 28th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward Jos. Winkler

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Lida Graham

13 BIRTHPLACE OF MOTHER (city or town) Phila Pa
(State or country)

14 Informant Edward Jos. Winkler
(Address) 119 N. Fenttle St.

15 Filed FEB 21 1923, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1923, to Feb 19, 1923,

that I last saw him alive on Feb 19, 1923

and that death occurred, on the date stated above, at 2.00 p. m.

The CAUSE OF DEATH* was as follows:

Premature Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Diarrhoea

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? No.

(Signed) [illegible], M. D.

Feb 21st, 1923 (Address) 3317 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Feb. 21st 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72787

CERTIFICATE OF DEATH.

129 D72787

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 26 WARD)

2-FULL NAME John Montgomery

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 666

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 19 23

17

I HEREBY CERTIFY, That I attended deceased from January 27, 1923, to February 17, 1923.

that I last saw him alive on February 16, 1923,

and that death occurred, on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? - no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde O'Neil, M. D.

2-17-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

Par. Wm. E. WOODALL.

FEB 21 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72788

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D72788

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 W. Biddle ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Davis

(a) RESIDENCE. No. 422 W. Biddle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 19, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Floyd Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Bessie Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Bessie Davis (Address) 422 W Biddle St

15 Filed FEB 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 17, 1923, to Feby 19, 1923, that I last saw her alive on Feby 18, 1923, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pettekoin, M. D.

, 19 (Address) 817 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Keyser W. Va.	2/23 1923
20 UNDERTAKER	ADDRESS
Jas. H. Skinner	1625 E. Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D72789

HEALTH DEPARTMENT—CITY OF BALTIMORE

129-D72789

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Harris

(a) RESIDENCE NO. 1225 High Alley. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	50	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary's Co., Md.

PARENTS

10 NAME OF FATHER Joe Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Mary's Co., Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Mary's Co., Md.

14 Informant Municipal Hospital Records.

(Address)

15 Filed FEB 21 1923 ROBERT N. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1923

17

I HEREBY CERTIFY, That I attended deceased from February 6, 1923, to Februayr 18 1923.

that I last saw her alive on February 18, 1923,

and that death occurred, on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Clyde Brent M. D.

2-19-1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel. DATE OF BURIAL Feb 22, 1923

20 UNDERTAKER Mrs. E. G. Locke ADDRESS 130 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72790

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D72790

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST. 9th WARD)

2-FULL NAME Emma Nolan

(a) RESIDENCE NO. 203 East ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given.

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Kingsold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed FEB 21 1923 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1923, to Feb. 19, 1923, that I last saw her alive on Feb. 19, 1923, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) yrs. 1 mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalaglisch, M. D.

2-19-1923 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem. DATE OF BURIAL Feb. 21. 1923

20 UNDERTAKER Mrs. J. E. Locks. ADDRESS 1302 Jefferson St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72791

CERTIFICATE OF DEATH.

100-001

D72791

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerald Munter

(a) RESIDENCE NO. 1410 Hollins St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE Years Months 14 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Munter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant John Munter

(Address) 1410 Hollins St

15 FEB 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/20, 1923, to 2/20, 1923

that I last saw him alive on 2/20, 1923

and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Leon Friedman, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL 2-21-1923

20 UNDERTAKER Robt Brooks & Son

ADDRESS 1410 Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72792

CERTIFICATE OF DEATH.

D72792

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 Aliceanna ST., 2 WARD)

2-FULL NAME Rosa Chrzanowska

(a) RESIDENCE No. 1713 Aliceanna ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 11, 1901.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	22	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home,

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, MD.

PARENTS

10 NAME OF FATHER John Chrzanowski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Mary Kalita,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant John Chrzanowski,
(Address) 1713 Aliceanna Street

15 Filed ..... 19 Burial Permit Clerk. Registrar

FEB 21 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febry. 19 1923.

17 I HEREBY CERTIFY, That I attended deceased from September, 1921, to Feb. 19, 1923.

that I last saw her alive on Feb. 19, 1923

and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Diarrhoea

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) John H. Rehberger, M. D.

, 19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem	Febry 24, 1923.
20 UNDERTAKER	ADDRESS
M. F. Sadowski	706 S. Ann

NOTICE—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72793

CERTIFICATE OF DEATH.

D72793

X 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (ST.:) 9 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam F. Kraemmel

(a) RESIDENCE. No. Fullerton, Balto Co. ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Kraemmel

6 DATE OF BIRTH (month, day, and year) Nov. 10 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Tailor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Wm Louis Kraemmel

(Address) 11 Batavia Ave Hamilton

15 Filed FEB 21 1923

16 WILLIAM N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1923 to Feb 19, 1923.

that I last saw h[e] alive on Feb 19, 1923.

and that death occurred, on the date stated above, at 3 25 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal (Sec.) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) S W Lowery, M. D.

, 19 (Address) St Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Feb 22 1923

20 UNDERTAKER: Henry Koch Son — ADDRESS: 1308 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Brooklyn.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72794

CERTIFICATE OF DEATH.

101-001

D72794

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2406 (St.) Vondenhorst (Ward) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Stoff

(a) RESIDENCE. No. 2406 Vondenhorst St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 6 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Martha T. Stoff

6 DATE OF BIRTH (month, day, and year): July 30 1873

7 AGE — Years: 49 — Months: 6 — Days: 21 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John E. Stoff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Mary A. Kuene

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant: Mrs. Elizabeth Hartman

(Address) 2406 Vondenhorst Lane

15 Filed . 19

EUGENE R. KRAUTER, Registrar

Burial Permit Clerk.

FEB 21 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-21- 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 . 1923, to Feb 21 . 1923, that I last saw him alive on Feb 21 . 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Signs

(Signed) Dannie Millet, M. D.

. 19 (Address) 1506 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Febry 24 1923

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E. Eager St

Spec.—1-10-21—M&T—1500 Bks.

D72795

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

D72795

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 945 Somerset ST., 10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph R Douglass

(a) RESIDENCE NO. 945 Somerset ST., 10 WARD .....

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 78 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant M. Ambrose Douglass

(Address) 945 Somerset St

15 Filed FEB 21 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1922, to Feb. 20, 1923,

that I last saw him alive on Feb. 19, 1923,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the rectum

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edwin B. Fenby, M. D.

2/20/1923 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Feb 23 1923

20 UNDERTAKER Henry Hoeck's Son — ADDRESS 1301 E. Eager st

BURIAL PERMIT SHOULD be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Spec. 1-10-21 M&T 1500 Blks.

D72796

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D72796

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 19 WARD)

2-FULL NAME Eliza Banks

(a) RESIDENCE No. 400 Parrish Alley ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	75	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework NO

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West River, Md.

PARENTS

10 NAME OF FATHER John Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lillian Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis.

14 Informant Municipal Hospital Records. (Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 19 23

17

I HEREBY CERTIFY, That I attended deceased from February 9, 19 23, to February 20 19 23,

that I last saw her alive on February 19, 1923,

and that death occurred, on the date stated above, at 2:35 A.M. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Otto Marx, M. D.

2-20-19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 2-22 19 23

20 UNDERTAKER George H. Holland

ADDRESS 1631 Druid Hill Ave.

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72797

CERTIFICATE OF DEATH.

X 31 ✓

D72797
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marrow Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dionisio Mediona

(a) RESIDENCE NO. 2467 Sacramento Cal ST., WARD California
(Usual place of abode) (If non-resident give City or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant Marine

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philippine I.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Morrow Hosp. Records
(Address)

15 Filed FEB 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 20 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-14 1922, to 2-20 1923, that I last saw h alive on 2-20 1923 and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Tubercular Pleurisy

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Physical & Examination

(Signed) P. E. Schoole, M. D.

2/21/1923 (Address) Morrow Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL 2/21 1923

20 UNDERTAKER A. Pierson & Bro

ADDRESS 1127 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72798

CERTIFICATE OF DEATH.

90 D72798

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE—(No.) 603 Edgerale Road (WARD) 27

2-FULL NAME Henry Rogers

(a) RESIDENCE NO. 603 Edgerale Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of Abraham Rogers

6 DATE OF BIRTH (month, day, and year) — — 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wool pld

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Eliz Rogers (Address) 603 Edgerale Road

15 FILED FEB 21 1923 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1923, to Feb. 20, 1923, that I last saw her alive on Feb. 20, 1923, and that death occurred, on the date stated above, at 10.55 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

Hypostatic pneumonia (about 2 days)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Aortic cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) A. F. Rus M. D.

Feb 20, 1923 (Address) 24 S. B'dway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL 2/23 1923

20 UNDERTAKER J. F. Tabeyrenc ADDRESS 131 Light St

Spec.—1-10-21—M&T—1500 Bks.

D72799 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D72799

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Nicoll Ave ST., Graas. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma C. Weaver

(a) RESIDENCE NO. 502 Nicoll Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Weaver

6 DATE OF BIRTH (month, day, and year) 10/9/1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER John S. Funk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant John L. Weaver. (Address) 502 Nicoll Ave.

15 Filed FEB 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1922 to Feb. 19 1923, that I last saw h[illegible] alive on Feb 18 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral Hemorrhage)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. M. Gehle M. D.

Feb 21, 1923 (Address) 2431 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Marysville Penna. DATE OF BURIAL 2/22/23.

20 UNDERTAKER J. W. Jenkins ADDRESS 1033 E. North Ave.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72800

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-00

D72800

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., 15 WARD)

2-FULL NAME Mary A. McGonigal

(a) RESIDENCE NO. 1929 Clifton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Ella McG.

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 yr.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

086

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: Mrs Ella McGonigal

(Address) 1929 Clifton Ave

15 Filed , 19 Robert F. Harrison, Registrar

FEB 21 1923

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1923, to Feb. 18, 1923

that I last saw him alive on Feb. 18, 1923

and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Chr. Nephritis — Hypertension

Lobar Pneumonia-Both bases- Multiple Thrombo-Embolitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes Clinical-Autopsy

What test confirmed diagnosis?

(Signed) O. G. Caldwell, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Feb. 22 1923

20 UNDERTAKER: H. Sanders & Sons — ADDRESS: 1710 Fleet St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72801 D72801

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 259 Patapsco West (St. or AVE.) WARD)

2-FULL NAME Norman E. Parker

(a) RESIDENCE NO. 259 Patapsco West WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1, 1922

7 AGE — Years: 7 — Months: — Days: 19 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Kate Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: William Parker

(Address) 259 Patapsco St Westport

15 Feb 21 1923 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1923, to Feb 20, 1923, that I last saw him alive on Feb 20, 1923 and that death occurred, on the date stated above, at 10 is P. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) no yrs. no mos 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Complete

(Signed) Raymond S. Edwards, M. D.

Feb 21, 1923 (Address) Parkland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Feb 24 1923

20 UNDERTAKER: N. E. Stiles — ADDRESS: 370 N. Arch St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Measles

Spec.—6-9-19—H. P. Co.—1000 Bks.

Payne

D72802

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D72802

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 703 Raysburg 1st. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dortha R. Payne

(a) RESIDENCE. NO. 703 Raysburg 1st. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 20 1921

7 AGE: Years 1 Months 2 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Robert Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mable Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mable Payne

(Address) 703 Raysburg St.

15 Received, 19 Robert E. Carlson, Registrar

Burial Permit Clerk

5 21 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13 1923 to Feb 20 1923

that I last saw h alive on Feb 19 1923

and that death occurred, on the date stated above, at 12.55 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Do Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home 7.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagn Characteristic Symptoms

(Signed) C. H. Thomas, M. D.

(Address) Feb 20, 1923 714 S. Bond Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Lawn

DATE OF BURIAL: 2-22-1923

20 UNDERTAKER: Daniel Carlson

ADDRESS 916 Pa Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D72803

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D72803

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Feldner

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	~~Unknown~~ Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Feldner ~~Unknown~~

6 DATE OF BIRTH (month, day, and year) ~~1839~~ 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80 ~~83~~	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed Robert P. Harrison, Registrar

3 2 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 19 23

17 I HEREBY CERTIFY, That I attended deceased from November 30. 19 21. to February 20. 19 23.

that I last saw her alive on February 19 . 19 23.

and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature] M. D.

2-20-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery DATE OF BURIAL Feb 22 19 23

17 UNDERTAKER F. D. Shippert ADDRESS 2216 Fred Ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72804

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72804

CERTIFICATE OF DEATH.

REGISTERED No. C 167

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2239 Pennsylvania Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James B Turner

(Residence in Baltimore: No. 2239 Pennsylvania) 20 St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Don't know (Month) (Day) 1 (Year)

7-AGE about 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Charles B Harman

11-BIRTHPLACE OF FATHER (State or Country). Virginia

12-MAIDEN NAME OF MOTHER Amelia Hanney

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W C Turner

(Address) Lodge Landing Va

15- Robert P. Harrison,

Filed ... 19...

Burial Permit Clerk. Registrar.

FEB 21 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 19, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by asphyxiation (illuminating gas)

(Duration) 6 hrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Stevenson (Coroner) M. D.

Feb 21 1923 (Address) 230 E Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lodge Landing Va

DATE OF BURIAL, 2-24, 1923

20-UNDERTAKER, Wm Cook

ADDRESS, 502 E North

BC

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72805

CERTIFICATE OF DEATH.

31

D72805

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2632 Lehman ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick H Newton

(a) RESIDENCE NO. 2632 Lehman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth 58 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Daisy E Newton

6 DATE OF BIRTH (month, day, and year): Aug 15 1865

7 AGE: Years 58 Months 6 Days 5

If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House

(b) General nature of industry, business, or establishment in which employed (or employer): Carpenter

(c) Name of employer: Fry & Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Isaac Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Susan Pointer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Daisy E Newton

(Address) 2632 Lehman St

15 Filed FEB 21 1923, 19 ... Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 1923

17 I HEREBY CERTIFY, That I attended deceased from February 6, 1923, to February 20, 1923, that I last saw him alive on February 19, 1923, and that death occurred, on the date stated above, at 9 45a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert E Gatch, M. D.

2/20 1923 (Address) 2151 Walker ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Feb 23 1923

20 UNDERTAKER: William Lud — ADDRESS: 502 E North Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72806

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. .....

CITY OF BALTIMORE: (No. LOCUST AVE. 2nd. DOOR WEST OF ST. OR HICKORY AVE. OVERLEA (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JANE MILLER

(a) RESIDENCE No. LOCUST AVE. 2nd. DOOR WEST OF HICKORY AVE. OVERLEA
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	WIDOWED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: CALVIN P. MILLER

6 DATE OF BIRTH (month, day, and year): MAY 22 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: HOUSEWORK

(b) General nature of industry, business, or establishment in which employed (or employer): AT HOME

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): CAVETOWN MD. MARYLAND

PARENTS

10 NAME OF FATHER: JOHN W. WALTZ

11 BIRTHPLACE OF FATHER (city or town) (State or country): CAVETOWN MARYLAND

12 MAIDEN NAME OF MOTHER: MARY WINTERS

13 BIRTHPLACE OF MOTHER (city or town) (State or country): CAVETOWN MARYLAND

14 Informant: LOTTIE L. MILLER
(Address): LOCUST AVE. OVERLEA MD.

15 8 21 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): FEB. 19 19 23

17 I HEREBY CERTIFY, That I attended deceased from July 15 1923 to Feb 8th 1923, that I last saw h alive on Feb 8th 1923, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

arterio sclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis? Clynical Signs

(Signed) Edw A Bedson, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: SMITHSBURG MARYLAND — DATE OF BURIAL: FEB 22 19 23

20 UNDERTAKER: Fred. Fossamon Sons — ADDRESS: FULLERTON MD.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. THIS IS A PERMANENT RECORD. Every item of in-

D72807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D72807

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 540 Green Mellon St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanor Bright

(Residence in Baltimore: No. 540 Green Mellon St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	colored	Married

6-DATE OF BIRTH. Feb. 21 1868
(Month) (Day) (Year)

7-AGE. 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Va.

PARENTS.

10-NAME OF FATHER. Robt Sanders

11-BIRTHPLACE OF FATHER, (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Eliz Read

13-BIRTHPLACE OF MOTHER, (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Richard Bright

(Address) 540 Green Mellon St.

15- Filed 1923 Robert P. Harrison, JOHNS HOPKINS HOSPITAL 192 Daniel Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb. 21 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) O. T. Hennig M. D.
(Coroner)

Feb. 21 1923 (Address) 2802 Eutaw Pl

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. 19

20-UNDERTAKER. Commissioner Health, ADDRESS FEB 21 1923

Per. Wm. E. WOODALL.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D72808

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72808

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 S. Charles ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas E. Trail

(a) RESIDENCE NO. 1736 S. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Trail

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or .... min.
57				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work City Employee.

(b) General nature of industry, business, or establishment in which employed (or employer) Watchman 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrodsburg Ky.

PARENTS

10 NAME OF FATHER Chas. Trail.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harrodsburg Ky.

12 MAIDEN NAME OF MOTHER Margaret Crain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Trail

(Address) 1736 S. Charles St.

15 Filed 1923 by Robert F. Harriser, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 20, 1923, that I last saw h[illegible] alive on Feb 19, 1923, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Cystic Kidney (Surgical)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

Feb 20, 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL Feb 22 1923

20 UNDERTAKER Margaret J. Flynn ADDRESS 1422 Light St

D 2 1923

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72809

D72809

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1217 Letitia St. (Ward) 25

2-FULL NAME Henry Burg

(a) RESIDENCE NO. 1217 Letitia Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Burg

6 DATE OF BIRTH (month, day, and year): June 30, 1900

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
22	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: Michael Burg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Agatha Weil

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Michael Burg

(Address) 1217 Letitia Ave.

15 Filed 2 1 1923, 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2 – 20 1923

17

I HEREBY CERTIFY, That I attended deceased from 2 – 14, 193.., to 2 – 20, 1923,

that I last saw him alive on 2 – 20, 1923

and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Signs

(Signed) [illegible], M. D.

Feb 21, 1923 (Address) 54 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem Co

DATE OF BURIAL: Feb 21 1923

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1422 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D. 72810 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 72810

D72810 CERTIFICATE OF DEATH. 123 D72810

1-PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE: (No. Maryland General Hospt ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Horsey

(Residence in Baltimore: No. 1606 St. Paul St.; 1 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Aug. 11th, 1865 (Month) (Day) (Year)

7-AGE, 57 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Somerset Co. Md.

PARENTS.

10-NAME OF FATHER, Samuel Tull

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Horsey

(Address) 1606 St. Paul St.

15-

Filed 1923, 191

Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 20, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 4 1923, to Feb. 20 1923, that I saw h[er] alive on Feb. 20 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

Cholelithiasis (one)

(Duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Chronic Pancreatitis

(Duration) yrs. mos. 16 ds.

(Signed) James Hart Wilkerson M. D.

Feb. 20, 1923 (Address) Md. Sanitarium

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 16 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence 1606 St. Paul St.

19-PLACE OF BURIAL OR REMOVAL, Marion, Somerset Co. Md. DATE OF BURIAL, 2/22/1923

20-UNDERTAKER E. D. Fanning & Son-1938 ADDRESS E. Lafayette Ave

Remarks No Operation

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—1-10-21—M&T—1500 Bks.

D72811

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D72811

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank STojcnofsky

(a) RESIDENCE NO. 13131 E Pratt. St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
38	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER John STojcnofsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Municipal Hospital Records.

(Address)

15 Filed 2-21 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1923

17

I HEREBY CERTIFY, That I attended deceased from February 19, 1923, to February 20 1923.

that I last saw him alive on February 20, 1923,

and that death occurred, on the date stated above, at 10:20 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKay M. D.

2-21-1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 2/22 1923

20 UNDERTAKER William Fialkowski 1618 Eastern

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of infor-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72812

CERTIFICATE OF DEATH.

49

D72812

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 Roland Heights St., 27 WARD)

2-FULL NAME Anna G Downs

(a) RESIDENCE No. 1010 Roland Heights St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel A Downs

6 DATE OF BIRTH (month, day, and year): May 17

7 AGE — Years: 60 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John R. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Susan Plunkert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: R. M. Gibson

(Address): 1010 Roland Ave

15 Robert F. Harrison, Registrar

MAR 21 1923, 19

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 4, 1922, to Feb. 20, 1923.

that I last saw h[illegible] alive on Feb 20, 1923.

and that death occurred, on the date stated above, at 1030 P m.

The CAUSE OF DEATH* was as follows:

Epithelioma Bladder

(duration) 1 yrs. 2 mos 16 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) C R Evans M. D.

3/21, 1923 (Address) 865 W. 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W x O W Cem'y — DATE OF BURIAL: 2/22/1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Nmk

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D72813

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72813

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Mercy Hospital St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas E. Thomas

(a) Residence No. 1113 E. Orleans St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): Dec 25 186[illegible]

7-AGE: 60 yrs. 1 mos. 26 ds. If LESS than 1 day, hrs. or mts.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Elevator Man

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Greece

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14- (Informant) Mrs. W. L. Sammons

(Address) 41 Royal Oak Ave.

15- Filed 192? Robert P. Harrison, Registrar.

FEB 21 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 2-21-23

I HEREBY CERTIFY, That I attended deceased from Feb. 19 1923 to Feb. 21 1923

that I last saw him alive on Feb. 21 1923

and that death occurred, on the date stated above, at 12 M. P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Heart failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym. & Signs

(Signed) A. J. Stevens M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: 2/24 1923

20-UNDERTAKER: W M Cook

ADDRESS: 502 E North Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72814

CERTIFICATE OF DEATH.

118-002 D72814

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Lake Ave + M & P. R.R. 27 (St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Cecilia Wagner

(a) RESIDENCE NO. Lake Ave + Md. & Pa. R.R. (St.) WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 17-

7 AGE — Years: 56 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) - (State or country): Maryland

PARENTS

10 NAME OF FATHER: Gustave J. Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Metz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: A. F. Wagner

(Address): Lake Ave + Roland Park

15 Filed FEB 2 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1923, to Feb 20, 1923.

that I last saw her alive on Feb. 20, 1923.

and that death occurred, on the date stated above, at 6-35 A m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) 11 hours

CONTRIBUTORY (Secondary) Chronic Mitral Endocarditis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Gibson Portis M. D.

2/20, 1923 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Long Green, Md St Johns — DATE OF BURIAL: 2/23 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 North Ave

IMPORTANT, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72815

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001 D72815

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 S. Calhoun St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Douglas C. Martin

(Residence in Baltimore: No. 117 S. Calhoun St.; yrs. 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. Jan (Month) 30 (Day) 1855 (Year)

7-AGE. 68 yrs. mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of Industry, business, or establishment in which employed (or employer). Roamer

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Smith T. Martin

11-BIRTHPLACE OF FATHER, (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Mary Crozall

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lulu Darney

(Address) 117 S. Calhoun

15-

Filed ..... 192.....

Robert P. Harrison,
Registrar.

Burial Permit (Clerk

2 21 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 20 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by illuminating Gas accident

(Duration) sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Hanlon M. D.
(Coroner.)

Feb 21 1923 (Address) 700 E. Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Orange Virginia	Feb 23 1923

20-UNDERTAKER.	ADDRESS
W M Cook	502 W Nor

Do not write above this line. Full name of informant should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72816

CERTIFICATE OF DEATH.

21 D72816

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 E Preston st ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary. E Cook.

(a) RESIDENCE No. 1735 E Preston St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late. C. Cook.

6 DATE OF BIRTH (month, day, and year): Dec 17/1887.

7 AGE: Years 35 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Charles County Md.

PARENTS

10 NAME OF FATHER: Charles Lemke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Charles County.

12 MAIDEN NAME OF MOTHER: M. Dengler.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: E. Cook.

(Address): 1720 Preston st

15 FEB 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17th 19 23

17 I HEREBY CERTIFY, That I attended deceased from Feb 14th, 19 23, to Feb 17th, 19 23,

that I last saw h— alive on Feb 15th, 19 23

and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Erysipelas of face

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Mitral insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) L. McCarter, M. D.

Feb 20, 19 23 Address) 1111 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: Feb 26 1923

20 UNDERTAKER: Geo. J. Ruth

ADDRESS: 1735 Harlem Ave.

INFORMATION, WRITE UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72817

CERTIFICATE OF DEATH.

X 31

D72817

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marrow Hospital ST., 16 WARD)

2-FULL NAME Elias Hendrickson

(a) RESIDENCE NO. Denmark ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant Seaman

(c) Name of employer —

9 BIRTHPLACE (city or town) Denmark (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Patient's History (Address)

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-20 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-17, 1923, to 2-20, 1923, that I last saw him alive on 2-20, 1923 and that death occurred, on the date stated above, at 8.38 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) P. E. Schools, M. D.

, 19 (Address) Marrow Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Feby 24 23

20 UNDERTAKER Robt. H. Turner

ADDRESS N. Bway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72818

CERTIFICATE OF DEATH.

D72818

REGISTERED NO. C 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Avenue Hospital ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C Beyer

(Residence in Baltimore: No. 1538 N. Washington St.) (44 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, August 9, 1878
(Month) (Day) (Year)

7-AGE, 44 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Ship Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) 115

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Christian Beyer

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Dora Jubb

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ira Beyer

(Address) 1538 N. Washington

15- Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 21, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 20 1923, to February 21 1923, that I saw h. m alive on Feb 20 1923, and that death occurred, on the date stated above, at 9.50 m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Enteritis

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Chas Lisbon Stewart M. D.
By permission of Coroner

(Address) 1738 E. 20th St. 2-22-1923

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park

DATE OF BURIAL, Feby 24 1923

20-UNDERTAKER Gladden Thomson

ADDRESS W. Baltimore

See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72819 D72819

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO. 161-006

CITY OF BALTIMORE, (No. 6 St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Patrick Stokes Jr.

(a) RESIDENCE NO. Sparrows Pt Md St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 hrs How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sparrows Pt Md

PARENTS

10 NAME OF FATHER Joseph P. Stokes

11 BIRTHPLACE OF FATHER (city or town) Bethlehem (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Pearl Montevercle

13 BIRTHPLACE OF MOTHER (city or town) Pittsburgh (State or country) Pennsylvania

14 Informant Joseph P. Stokes (Address) 117 E 21st Sparrows Pt

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1923, to Feb 20, 1923, that I last saw h[illegible] alive on Feb 20, 1923, and that death occurred, on the date stated above, at 10:25 p. m.

THE CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 20, 1923

Was there an autopsy?

What test confirmed diagnosis? Operation - Clinical Findings

(Signed) Cayetano Paunetto M. D.

, 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Feb 22 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72820

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72820

CERTIFICATE OF DEATH.

164

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 204 East Church ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia A Joynes

(a) RESIDENCE NO. 204 East Church ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Tankard Joynes

6 DATE OF BIRTH (month, day, and year): Dec 19 1857

7 AGE: Years 71 | Months 2 | Days — | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at

(b) General nature of industry, business, or establishment in which employed (or employer): her home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: S. Kline

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary Ann Kline

(Address): 204 East Church st

15 Filed FEB 22 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 2nd 1922 to Feb 19 1923.

that I last saw h/r alive on Feb 19 1923.

and that death occurred, on the date stated above, at 11-45 p m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D.D. Burton, M. D.

2/24, 1923 (Address) 307 E Eleventh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Cemetery Stampden

DATE OF BURIAL: Feb 22 1923

20 UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

Spec.—1-10-21—M&T—1500 Bks.

D72821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D72821

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 N Monroe ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Ezra A. Dickey

(a) RESIDENCE NO. 14 N. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Dickey

6 DATE OF BIRTH (month, day, and year) Nov 14 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	3	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) Medical

(c) Name of employer

9 BIRTHPLACE (city or town) Sterling (State or country) Illinois

PARENTS

10 NAME OF FATHER David Dickey

11 BIRTHPLACE OF FATHER (city or town) Sterling (State or country) Illinois

12 MAIDEN NAME OF MOTHER Margaret Ziegler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant David D. Dickey (Address) 14 N. Monroe Street

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 19 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 5 1923, to Feb 19, 1923

that I last saw he alive on Feb 18, 1923,

and that death occurred, on the date stated above, at 7 - A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C Ostrander Smith, M. D.

, 19 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Feby 22 1923

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W. North ave

Spec.—1-10-21—M&T—1500 Bks.

Rue

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D72822 D72822

CERTIFICATE OF DEATH.

X 47

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 14 WARD)

2-FULL NAME Mrs. Mary Holmes Rue

(a) RESIDENCE NO. Cream Ridge, N.J. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced, (write the word)~~: Widowed

5a If married, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of: James L. Rue

6 DATE OF BIRTH (month, day, and year): Feb. 1 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): N. J.

PARENTS

10 NAME OF FATHER: Joseph Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER: Martha Weir

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. J.

14 Informant: M. Rue.
(Address) Cream Ridge N. J.

15 FEB 22 1923 ROBERT R. KRAUTER, Registrar
~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 , 1923 , to Feb 21 , 1923 , that I last saw her alive on Feb 21 , 1923 , and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast Left

(duration) 4 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Broncho Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 17, 1923

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. B. Cruce, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cream Ridge N.J.	Feb 22 1923
20 UNDERTAKER: Henry H. Jenkins Sons	ADDRESS: McCulloh & Oakland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.–1-10 21 M&T 1500 Bks.

D72823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

178 D72823

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 N. Charles ST., 11 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Irvin

(a) RESIDENCE NO. 1120 N. Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~ Single

5a If married, widowed, or divorced ~~HUSBAND of (or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) 1857-5-31

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
65	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Johua Irvin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emily Clautice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Miss Irvin
(Address) 1120 N. Charles St

15 FEB 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to July 20, 1923, that I last saw h.. alive on July 19, 1923, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albuminuria + casts in urine followed by oedema

(Signed) Chas. O. Donovan, M. D.

2-21, 1923 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 2-23 1923

20 UNDERTAKER Henry J. Watkins & Sons Co — ADDRESS McCulloh & Richard

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72824

CERTIFICATE OF DEATH.

91-00 D72824

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Battery Ave ST.) (24th WARD)

2-FULL NAME Barbara Kappauf

(a) RESIDENCE. NO. 1514 Battery Ave ST., 24th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? 28 yrs. 6 mos. 0 ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Friederich Kappauf.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Marie M. Noell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charlotta Beil. (Address) 1514 Battery Ave

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to Feb 20, 1923, that I last saw h er alive on Feb 19, 1923, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Asthma

(duration) 0 yrs. 3 mos. 0 ds.

CONTRIBUTORY (Secondary) Sclero Sclerosis,

(duration) 10 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1243 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	2/23/ 23

20 UNDERTAKER ADDRESS

E. J. Fanning & Son - 1440 Battery Ave

D72825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D72825

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 606 Forrest St 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Harris

(Residence in Baltimore: No. 606 N. Forrest st St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced (Write the word.): Sgle

6-DATE OF BIRTH: Dec (Month) 31 (Day) 1922 (Year)

7-AGE: .....yrs. 1 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS:

10-NAME OF FATHER: Jos Harris

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary Fools

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos Harris

(Address) 606 N Forrest st

15- Filed FEB 22 1923 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 21 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ Inquiry.) thereon and from the evidence obtained by said ~~Inquest, au~~ Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) 1 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Coed

(Duration) yrs. mos. 4 ds.

(Signed) W K Grinnell M. D. (Coroner.)

2 21 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt auburn ct — DATE OF BURIAL: Feb 22 1923

20-UNDERTAKER: S. L. Brown & Son — ADDRESS: 1610 Mondy St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72826

CERTIFICATE OF DEATH.

X 74-001

D72826

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Perkins

(a) RESIDENCE NO. Fairfield, Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48 approximately			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) 240

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Perkins. (Address) Fairfield, Md.

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/13, 1923, to 2/20, 1923, that I last saw h[illegible] alive on 2/20, 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

~~Cerebral Hemorrhage~~ ?

Cerebral Arterio Sclerosis

(duration) yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Pt. Cerebral Hemorrhage

(duration) yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? Patient.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Leon Strauss M.D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct	Feb 23 1923
20 UNDERTAKER	ADDRESS
A. L. Brown's Son	108 W Monty

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72827
1-PLACE OF DEATH

REGISTERED NO. 90 D72827

CITY OF BALTIMORE: (No. 2266 N Avenue ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Keys

(a) RESIDENCE. NO. 2266 N Avenue ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Keys
(Address) 2266 Madison St

15 Filed FEB 22 1923 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1923, to Feb 19, 1923, that I last saw h alive on Feb 19, 1923, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

Feb 20 1923 (Address) 937 Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL 2/22 1923

20 UNDERTAKER Edward P Bendley

ADDRESS 1758 W Baltimore

INFORMATION. WRITE PLAINLY WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72828

CERTIFICATE OF DEATH.

31

D72828

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 N. Rutland ave ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E J Taylor

(a) RESIDENCE No. 1006 N. Rutland ave ST., WARD 7

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Mulr

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 22 - 1882

7 AGE: Years 40; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Eugene J Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Eliza Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Charles Staylor 1006 Rutland Ave

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2 — 20 — 19 23

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 19 23 to Feb 20, 19 23

that I last saw h living on Feb 20, 19 23

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) F Full Signature, M. D.

2-21, 19 23 (Address) 800 N Rutland Ave Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ht Oakland Cem. — DATE OF BURIAL: Feb 23 23

20 UNDERTAKER: Henry Lutz — ADDRESS: 1203 Broadway

Spec.—1-10-21—M&T—1500 Bks.

Royster ✓

D72829

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D72829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1311 Jefferson ST. 5 WARD)

2-FULL NAME George M Royster

(a) RESIDENCE NO. 1311 Jefferson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: — — —

6 DATE OF BIRTH (month, day, and year): May 7 1922

7 AGE — Years: | Months: 9 | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William Royster

11 BIRTHPLACE OF FATHER (city or town) (State or country): V. C.

12 MAIDEN NAME OF MOTHER: Mamie Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): V. C.

14 Informant: Mamie Royster
(Address) 1311 Jefferson Street

15 FEB 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 15th 1923 to Feb 19th 1923, that I last saw him alive on Feb 18th 1923, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia — following Acute Bronchitis

(duration) ..... yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cold and Bronchitis (duration) 7 yrs. 9 mos. 3 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Lud Hall, M. D.

, 19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Feb. 22 1923

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 172 Aisquith

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72830

CERTIFICATE OF DEATH.

101-001

D72830

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 345 Rosebank ST., 27 WARD)

2-FULL NAME Annie E. Hawthorne

(a) RESIDENCE NO. 345 Rosebank ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: ~~HUSBAND of~~ Charles L. Hawthorne.

6 DATE OF BIRTH (month, day, and year): April 15, 1862

7 AGE — Years: 60 — Months: 10 — Days: 5 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED: At home

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Stevenson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary Guy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Charles E. Hawthorne 4302 Reade ave

15 Filed FEB 22 1923, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1923, to Feb 20, 1923, that I last saw h[illegible] alive on Feb 20, 1923, and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) ..... yrs. ..... mos. 12 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo H Hoskins, M. D.

, 19 (Address) 5835 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Feb 23 1923

20 UNDERTAKER: Zurkler & Zurkler — ADDRESS: 1734 Eager

N. B.—WRITE PLAINLY, WITH INDIA INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D72831

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fruitin Sq. Hosp. ST., 12 WARD)

2-FULL NAME Geo. T. Harrison

(a) RESIDENCE NO 814 Powers ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Harrison

6 DATE OF BIRTH (month, day, and year) April 10, 879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cable Splicer

(b) General nature of industry, business, or establishment in which employed (or employer) C & P

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Geo. T. Harrison

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Tucker

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Mary E. Harrison (Address) 814 Fawn st

15 FEB 22 1923 HUGENE A. KRAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/19 - 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-15- , 1923 , to 2-19- , 1923 , that I last saw him alive on 2-19- , 1923 , and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Conjestive chills

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 2-17-23

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Knox & Penn, M. D.

2-19-, 1923 (Address) Fruitin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Feb 22 1923
20 UNDERTAKER Fertsch & Fertsch	ADDRESS 1134 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72832 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

49 D72832

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hospital St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Roman Ward Jr

(a) RESIDENCE No. 1230 W. Lafayette ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 07 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 26 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	07	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Manager & Treasurer

(b) General nature of industry, business, or establishment in which employed (or employer): Greenmount Iron Manufacturing Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James R. Ward Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Mary A. Lawson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Robert Lawson Ward (Address) 1230 W. Fayette ave

15 FEB 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 20, 1923.

17 I HEREBY CERTIFY, That I attended deceased from February 1st, 1923, to February 20th, 1923, that I last saw him alive on February 20th, 1923, and that death occurred, on the date stated above, at 11-30 P m.

The CAUSE OF DEATH* was as follows:

Papillary carcinoma of urinary bladder,

(duration) One yrs mos ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis and senility. (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) C. W. S. Kohrer, M. D.

, 19 (Address) 22 Ailsa Avenue.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Feby 24 1923

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72833 — CERTIFICATE OF DEATH. — 100-001 — D72833

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3635 Chestnut Ave ST., (WARD) 15

2-FULL NAME Josephine Elizabeth Laggett.

(a) RESIDENCE No. 3635 Chestnut Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Luther E. Laggett.

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE — Years: 66 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Bruce E. Laggett

(Address) 3635 Chestnut Ave.

15 FEB 22 1923

ROBERT R. KRAMER
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 9, 1923, to Feb 21, 1923, that I last saw h[illegible]ive on Feb 20, 1920, and that death occurred, on the date stated above, at 2-42 A m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos 1½ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) R. B. Normant, M. D.

2-24-1923 (Address) 3638 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL: Howard Chapel, Montgomery Co.

DATE OF BURIAL: Feb 23, 1923.

20 UNDERTAKER: Cromwell & Son.

ADDRESS 3876 Chestnut Ave

N. B.—WRITE PLAINLY, WITH INKS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D72834

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001

D72834

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3648 Elm Ave ST., 13 WARD)

2-FULL NAME Sarah Virginia Towson

(a) RESIDENCE NO. 3648 Elm Ave. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James H. Towson

6 DATE OF BIRTH (month, day, and year): Sept. 26-1855

7 AGE — Years: 67 — Months: 4 — Days: 24 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kent Co. Maryland

PARENTS

10 NAME OF FATHER: Solomon Eagle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Barkley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant (Address): James H. Towson 3648 Elm Ave

15 FEB 22 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10th, 1923, to Feb. 19th, 1923.

that I last saw her alive on Feb 19th, 1923.

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): La Grippe

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. Dreuer M. D.

2/21, 1923 (Address) 846 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's (Hampden)

DATE OF BURIAL: Feb. 22 1923.

UNDERTAKER: Horace H. Burgue

ADDRESS: 363 Hollo Rd.

D72835

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

D72835

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1338 N. Mulberry St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Joseph H. Jones

(Residence in Baltimore: No. 1338 N. Monroe St.; 13 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): single

6-DATE OF BIRTH: May 1, 1904 (Month) (Day) (Year)

7-AGE: 18 yrs. 9 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: student
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country): Md.

PARENTS:

10-NAME OF FATHER: John Brown

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Rachel Jones

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rachel Jones

(Address) 1338 N. Monroe St.

15-FEB 22 1923 Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 19, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. J. Hennessy M. D. (Coroner)

Feb. 20 1923 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Feb. 22 1923

20-UNDERTAKER: James H. Edmunds — ADDRESS 1309 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72836

CERTIFICATE OF DEATH.

167

D72836

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 12 So. Caroline St ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Caitlin

(Residence in Baltimore: No. 12 So. Caroline St.: 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH: Aug 12th, 1850 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
72 yrs. 6 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Church Sexton
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Otto M. Schroder

(Address) 107 Cedar ave, Roland Park

15- FEB 22 1923 Filed ....., 191.....

Burial Permit Clerk.

ROBERT R. KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 20th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Inhaling Illuminating Gas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton (Coroner.) M. D.

Feb 21st 1923 (Address) Curtis Bay, Balto, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	Feb 22 1923

20-UNDERTAKER	ADDRESS
J. E. Hughes	424 N. Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72837

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2019 Oak St.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Robert Williams

(Residence in Baltimore: No. ~~2044 E~~ 925 Norris st St.: 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word): Single

6 DATE OF BIRTH: September 22, 1882 (Month) (Day) (Year)

7 AGE: 40 yrs. 5 mos. ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Ind., Ice, Co.

9 BIRTHPLACE (State or Country): King & Queens, Co, Va,

PARENTS.

10 NAME OF FATHER: J. H. Williams

11 BIRTHPLACE OF FATHER (State or Country): King & Queens, Co, Va

12 MAIDEN NAME OF MOTHER: Hester Holloway

13 BIRTHPLACE OF MOTHER (State or Country): New Berne N. C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Williams

(Address) 3242 Barclay st

15 Filed FEB 22 1923 By ROBERT R. KRAUTER, Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. 17, 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Acute dilation of Heart.

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) John Morrissey M. D. (Coroner)

Feb 22 1923 (Address) 3652 Boulevard

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel, Md.

DATE OF BURIAL: 2/22 1923

20 UNDERTAKER: Jas M. Skinner

ADDRESS: 1625 E. Mad, st

Spec.—1-10-21—M&T—1500 Bks.

D72838

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D72838

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1506 Kenseett ST. 13 WARD)

2-FULL NAME Elizabeth Jane Doulcen

(a) RESIDENCE NO. 1506 Kenseett ST, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Peter Doulcen

6 DATE OF BIRTH (month, day, and year): Nov. 27, 1873

7 AGE — Years: 49 — Months: 2 — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Edward Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Maryland

12 MAIDEN NAME OF MOTHER: Mary Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Maryland

14 Informant (Address): Peter Doulcen 1506 Kenseett St. Balto Md

15 FEB 22 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10th, 1923, to Feb. 21st, 1923, that I last saw her alive on Feb. 21st, 1923, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) Elbert C Reitzel M. D.

Feb 21st 1923 (Address) Cor. Pa. & Fulton Aves. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Feb 23 1923

20 UNDERTAKER: Josiah Lyford — ADDRESS: Woodlawn Md

N. B.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72839

CERTIFICATE OF DEATH.

101-001

D72839

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 429 E. Preston St. ST., 11 WARD)

2-FULL NAME Catherine E. Burns

(a) RESIDENCE NO. 429 E. Preston St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Ignatius J. F. Burns

6 DATE OF BIRTH (month, day, and year): Feb 9-1863

7 AGE: Years 60 — Months — Days 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: J. B. Kellum

11 BIRTHPLACE OF FATHER (City or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Billinop Butt

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Va

14 Informant (Address): J. J. F. Burns 429 E. Preston St

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 19" 1923

17

I HEREBY CERTIFY, That I attended deceased from January 30th 1923 to February 19th 1923, that I last saw h e alive on February 19th 1923, and that death occurred, on the date stated above, at 11:40 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

[Type I.]

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary): Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No knowledge

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Pneumococcus agglutination

(Signed) John G. Hogan, M. D.

, 19 (Address) 7E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 2/23 1923

20 UNDERTAKER: Chas. F. Evans & Son — ADDRESS: 11 & W. Mt. Royal ave

WHITE PAPER, WITH CARBON INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72840

D72840

CERTIFICATE OF DEATH.

REGISTERED NO. 74001 D72840

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 1431 E. Hoffman ST., 9 WARD)

2-FULL NAME Minna C. Boucher

(a) RESIDENCE No. 1431 E. Hoffman ST., 9th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Boucher

6 DATE OF BIRTH (month, day, and year) Nov 11-1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Houseman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kirkwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sophia L. Stedler
(Address) 1431 E. Hoffman st.

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20" 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1923, to Feb. 20, 1923, that I last saw h[er] alive on " " 1923, and that death occurred, on the date stated above, at 1.[30] P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy with right hemiplegia 24 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. A. Hartman, M. D.

, 19 (Address) 2211 Maryside Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem. DATE OF BURIAL: 2/22" 1923

UNDERTAKER: Chas R. Evans & Son ADDRESS: 118 W. Mt Royal Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D72841

D72841

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 Hawthorn Road ST. 27th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cabell Seddon

(a) RESIDENCE NO. 119 Hawthorn Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes C. F. Judge

6 DATE OF BIRTH (month, day, and year) June 3, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Virginia

PARENTS

10 NAME OF FATHER James A. Seddon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Bruce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Agnes Seddon

(Address) 119 Hawthorn Road

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21. 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16. 1923, to Feb. 21. 1923, that I last saw h[illegible] alive on Feb. 20 1923, and that death occurred, on the date stated above, at 8-35 A. m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

Right Hemiplegia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) General Arterio-Sclerosis

(duration) 2? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Gibson Parlin M. D.

2/21, 1923 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	2/23 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72842 ✓ D72842

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 Aisquith St. ST. 10 WARD)

2-FULL NAME Daniel Haney

(a) RESIDENCE No. 1036 Aisquith St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. --- mos. -- ds. How long in U. S., if of foreign birth? 55 yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Fitzsimmons

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	----	--	

8 OCCUPATION OF DECEASED Retired

(a) Trade, profession or particular kind of work Cable Splicer

(b) General nature of industry, business, or establishment in which employed (or employer) Telephone

(c) Name of employer C. & P. Tel. Co.

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Bernard Haney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose----------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Rose Scally

(Address) 1036 Aisquith St.

15 Filed FEB 22 1923 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1923, to Feb 21, 1923,

that I last saw h is alive on Feb. 20, 1923,

and that death occurred, on the date stated above, at 1.45 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Thos F. Stevens, M. D.

2/21, 1923 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	2/23/23 19
20 UNDERTAKER	**ADDRESS**
Henry W. Mears & Son	805 Calvert

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72843

CERTIFICATE OF DEATH.

101-001 D72843

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 East Lafayette Ave ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ann Badders

(a) RESIDENCE NO. 217 East Lafayette Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James H. Badders

6 DATE OF BIRTH (month, day, and year): Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	---	---	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Francis McKew

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: Mary A. Plowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: Miss Cecelia Badders

(Address) 217 E. Lafayette Ave.

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1923, to Feb 20, 1923, that I last saw her alive on Feb 20, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Grippe

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald S. Tonry, M. D.

, 19 (Address) 414 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 2/23/23 19

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 Calvert St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72844

CERTIFICATE OF DEATH.

100-0 D72844

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1636 N. Smallwood St. WARD 15)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Berger Jr.

(a) RESIDENCE. NO. 1636 N. Smallwood St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 4 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John P Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Beatrice Perrin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant John P Berger
(Address) 1636 Smallwood St

15 FEB 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb'ry 16th, 1923, to Feb'ry 20th, 1923, that I last saw h[illegible] alive on Feb'ry 20, 1923, and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 12 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Brumm M. D.

2/24, 1923 (Address) 1701 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 23 1923
UNDERTAKER	ADDRESS
E. A. Wedefeldt Jr	501 E 22 St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72845

CERTIFICATE OF DEATH.

3/ D72845

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Engel

(a) RESIDENCE NO. 922 N. Chester st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Herman Engel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Pines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records (Address) M. T. H.

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1923, to Feb. 21, 1923, that I last saw him alive on Feb. 21, 1923, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 1 mos. 23 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? B. Bs. in sputum. X-ray

(Signed) Francis L Dodgkins M. D.

2-21-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rock Road

DATE OF BURIAL 2/22 1923

20 UNDERTAKER Jack Levis ADDRESS 1439 Eutaw St

INFORMATION CONCERNING THE DECEASED MUST BE GIVEN BY THE NEAREST RELATIVE OR OTHER PERSON KNOWING THE FACTS AS NEARLY AS POSSIBLE. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D72846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001 D72846

1-PLACE OF DEATH Hebrew Home

CITY OF BALTIMORE: (No. Monument & Loland Ave St., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Schneider

(a) RESIDENCE NO. 1705 Moreland Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furrier

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER David Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levin

(Address) 1439 Eastern Ave

15 FILED FEB 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit-Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 16th, 1923, to Feb 21st, 1923, that I last saw h[illegible] alive on Feb 21st, 1923, and that death occurred, on the date stated above, at 11 45 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

7 (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 2/19/23

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

2/21, 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 2/23 1923

20 UNDERTAKER Jack Levin — ADDRESS 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specificnlly the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Verified Herein

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72847

CERTIFICATE OF DEATH.

129 D72847

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 S. Caroline St. WARD 3)

2-FULL NAME Circus Koenigsberg

(a) RESIDENCE NO. 229 S Caroline St. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fradie Koenigsberg

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Pacey Koenigsberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fagie Finkelstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Balto St

15 FEB 22 1923 Filed ....., 19 ROBERT A. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1923, to Feb. 21, 1923, that I last saw him alive on Feb. 21, 1923, and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Frank Q. Smith, M. D.

, 19 (Address) 927 E. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hillcrest Cemetery Mortimer Cook Jr. Funeral Director — DATE OF BURIAL 2/23 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72848

CERTIFICATE OF DEATH.

49 D72848

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument & Port Castle St.) 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Dubovsky

(a) RESIDENCE NO. 110 N Wolfe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frieda Dubovsky

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE: Years 53; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 180

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Hyman Dubovsky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Esther —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: J. Krus

(Address): 1439 E. Balto. St.

15 Filed FEB 22 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21st 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 16, 19 22, to Feb 21st, 19 23.

that I last saw h[illegible] alive on Feb 21st, 19 23.

and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Malignant Carcinoma

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Prostate

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/29/22

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic Exam of Gland

(Signed) Robert Longhenner M. D.

, 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem Mt Carmel — DATE OF BURIAL: 2-23 1923

20 UNDERTAKER: Jack Krus — ADDRESS: 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Wanzee Jones.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72849

CERTIFICATE OF DEATH.

X 11-001 ✓

D72849

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 745 Raborg ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wanzee Jones

(a) RESIDENCE NO. 745 Raborg ST., WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? — yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept, 19, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	1	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk (State or country) Virginia

PARENTS

10 NAME OF FATHER Edward Jones

11 BIRTHPLACE OF FATHER (city or town) Emporia (State or country) Virginia

12 MAIDEN NAME OF MOTHER Xenia Oley

13 BIRTHPLACE OF MOTHER (city or town) Portsmouth (State or country) Virginia

14 Informant Edward Jones

(Address) 745 Raborg St

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb, 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb, 13, 1923, to Feb, 20, 1923,

that I last saw him alive on Feb, 20, 1923,

and that death occurred, on the date stated above, at 8, P, m.

The CAUSE OF DEATH* was as follows:

Acute Lobular Pneumonia

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) — yrs. — mos. 17 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) David Franklin, M. D.

2/21, 1923 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL Feb 24 23

UNDERTAKER R E Gross ADDRESS 1405 McElderry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72850

CERTIFICATE OF DEATH.

16 1 001 D72850

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2208-Christen St. ST.: 20 WARD)

2-FULL NAME James Connolly.

(a) RESIDENCE. NO. 2208-Christen St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): 2/20/23

7 AGE: Years / Months / Days / If LESS than 1 day, 3 hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: James Connolly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Josephine Eisel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: James Connolly
(Address): 2208-Christen St

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 19 23

17

I HEREBY CERTIFY, That I attended deceased from Feb 20, 19 23, to Feb 20, 19 23, that I last saw h.. alive on Feb 20, 19 23, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar (Lobar)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M D Jones, M. D.

2/21, 19 23 (Address) 720 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem.

DATE OF BURIAL: 2/22/23 19

20 UNDERTAKER: George J. Ruth

ADDRESS: 1330 Harford

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002 D72851

D72851
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Registered No. C.....

City of BALTIMORE: (No. Home for Aged- Little Sisters of Poor. St. 10)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Rollan

(Residence in Baltimore: No. Home for Aged Preston & Valley St.; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widow, Widower, Divorced. (Write the word.): Widow

6-DATE OF BIRTH, Nov. 14/1856 Feb. 21/23
(Month) (Day) (Year)

7-AGE. 66 yrs. 3 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Ga Ephram Nugent

PARENTS:

10-NAME OF FATHER. Ephram Nugent unknown

11-BIRTHPLACE OF FATHER, (State or Country). Emiline Toddy

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Home for Aged

(Address) Preston & Valley

15- FEB 22 1923
Filed 192.

ROBERT R. KRAUTER,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 21/23
(Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J S Haller M. D.
(Coroner.)

2/21/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. 2/23/23

20-UNDERTAKER. H. C. Wedefeld ADDRESS 914 Greenmount

Instructions: Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72852

CERTIFICATE OF DEATH.

Registered No. C

1-PLACE OF DEATH

City of BALTIMORE: (No 1533 N. Eden St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Harry Ignatius Fuller ...St.; yrs.. 44 ..mos.....ds.)

(Residence in Baltimore: No. 1533 N. Eden

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced (Write the word): ~~Married~~

6-DATE OF BIRTH: Oct. 16/23/78 (Month) (Day) (Year)

7-AGE: 44 yrs. 4 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: clerk

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R R Co

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Hehry Fuller

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Eliza Lutz

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. I. Fuller

(Address) 1533 N. Eden

15- Filed FEB 22 1923 ROBERT A. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 20/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Secondary Anaemia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Amoebic Dysentery (Duration) ....yrs. 3 or more mos. ....ds.

(Signed) [illegible] M. D. (Coroner.)

2/23/23 192.. (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem. DATE OF BURIAL, 2/23/23 19....

20-UNDERTAKER, A. C. Mudefield ADDRESS 914 Gwynn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72853

CERTIFICATE OF DEATH.

74-001 D72853

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N. Carey ST. WARD 19)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Swartz Gonzales

(a) RESIDENCE. NO. 508 N. Carey ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or divorced (or) WIFE of: Ferdinand J. S. Gonzales

6 DATE OF BIRTH (month, day, and year): Jan. 20 1843

7 AGE: Years 80 | Months 1 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Penna.

PARENTS
10 NAME OF FATHER: Charles Swartz
11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna
12 MAIDEN NAME OF MOTHER: Catharine Kepler
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Miss Frances Woodward
(Address) 508 N. Carey St.

15 Filed FEB 22 1923 ROBERT R. KRAUTER, Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 14 1922 to Feb 20 1923, that I last saw h 21 alive on Feb 20 1923 and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Arterio-sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Blood pressure X

(Signed) Ernest P. Gaither M. D.
, 19 (Address) #17 N. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Feb 23 1923
20 UNDERTAKER	ADDRESS
Chas. E. Franck & Son	Madison

Burial Permit Clerk

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

12620 D72854

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 12620 D72854

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3320 Fleet St. ST., 76 WARD)

2-FULL NAME Mary Margaret Baker

(a) RESIDENCE No. 3320 Fleet St ST., 76 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 21 - 1923.

7 AGE — Years | Months | Days | If LESS than 1 day 20 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Daniel Baker.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary M. Reise

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Daniel Baker 3320 Fleet St

15 FEB 23 1923 ALBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/21/23

17 I HEREBY CERTIFY, That I attended deceased from 2/21/23, 19 ..., to 2/21, 19 23, that I last saw h[illegible] alive on 2/21/23, 19 ..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

6 months foetus (Premature)

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) 6 months foetus

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. McGarrell, M. D.

2/22, 19 (Address) 1633 S. 3rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: Feb. 22 1923.

20 UNDERTAKER: Lilly and Zeibs

ADDRESS 403 S. Mo[illegible] St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

72354 D72855

HEALTH DEPARTMENT—CITY OF BALTIMORE

D23852

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. Cullen

(a) RESIDENCE NO. Catonsville Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of or WIFE of Fortune Cullen

6 DATE OF BIRTH (month, day, and year) Oct. 9th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Camden
(State or country) Delaware

PARENTS

10 NAME OF FATHER Ezakiah Cullen

11 BIRTHPLACE OF FATHER (city or town) Camden
(State or country) Delaware

12 MAIDEN NAME OF MOTHER Martha, J. Kimmey

13 BIRTHPLACE OF MOTHER (city or town) Camden
(State or country) Delaware

14 Informant Mrs Fortune Cullen
(Address) Catonsville md

15 Filed FEB 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1922 to Feb 21 1923 that I last saw him alive on Feb 21 1923 and that death occurred, on the date stated above, at 4.10 P m.

The CAUSE OF DEATH* was as follows:

acute Pancreatitis

(duration) yrs. 4 mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical Course

(Signed) W. C. Caldwell M. D.

2/22 1923 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waynesboro, Va. DATE OF BURIAL Feb 23 1923

20 UNDERTAKER Joseph L. Cook ADDRESS 1003 N. Calto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

12621 D72856

HEALTH DEPARTMENT—CITY OF BALTIMORE

12621 D72856

CERTIFICATE OF DEATH.

REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 729 N. Gaterwood ST., 7 WARD)

2-FULL NAME Infant. Schultz

(a) RESIDENCE NO. 729 N Gaterwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Feb 21-23

7 AGE — Years | Months | Days | If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Joseph F. Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Margaret McMahon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Joseph F. Schultz 729 N Gaterwood

15 Filed FEB 23 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 21, 1923, to Feb 21, 1923, that I last saw h[illegible] alive on Feb 21, 1923, and that death occurred, on the date stated above, at 8:20 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Lowe, M. D.

2/21, 1923 (Address) 1113 N Gaterwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: Feb 22 1923

20 UNDERTAKER: Lilly and Zeiler

ADDRESS: 403 S. Wolfe

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accident—drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital

Spec. 1-19-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72857

CERTIFICATE OF DEATH.

7H-001 D72857

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. SEVERN APARTMENTS ST., 11 WARD) MT VERNON PLACE & CATHEDRAL STS.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME DAVIES MURDOCH

(a) RESIDENCE No. SEVERN APARTMENTS ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred LIFETIME yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	DIVORCED

5a If married, widowed, or divorced
HUSBAND of
(or WIFE of) LOUISE McKIM

6 DATE OF BIRTH (month, day, and year) AUG 10, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ACCOUNTANT

(b) General nature of industry, business, or establishment in which employed (or employer) ESTATE

(c) Name of employer T. H. GAITHER

9 BIRTHPLACE (city or town) (State or country) BALTIMORE MD

PARENTS

10 NAME OF FATHER ALEXANDER A. MURDOCH

11 BIRTHPLACE OF FATHER (city or town) (State or country) BALTIMORE MD

12 MAIDEN NAME OF MOTHER FLORENCE DAVIES

13 BIRTHPLACE OF MOTHER (city or town) (State or country) BALTIMORE MD

14 Informant [illegible] Morris
(Address) 6 ROLAND AVE ROLAND PK.

15 Filed FEB 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21 1923

17

I HEREBY CERTIFY, That I attended deceased from 1/19 1923 to 2/19 1923

that I last saw him alive on 2/19 1923

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Cerebral vascular accident (duration) sudden yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis gradual over several years (duration) mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Indigo

(Signed) [illegible] M. D.

2/22 1923 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL 2-23 1923

20 UNDERTAKER Henry W. Jenkins Sons & McCullough ADDRESS Orchard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72858 31 D72858

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 481 Park Ave St. 77 WARD)

2-FULL NAME Nora Estelle Evans

(a) RESIDENCE NO. 481 Park Ave St.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fml

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adelaide Evans

6 DATE OF BIRTH (month, day, and year): April 2 1874

7 AGE: Years 48; Months 10; Days 18; If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Noah Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Jane Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Adelaide Evans

(Address) 481 Park Ave

15 FEB 23 1923 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 20, 1923, to Feby 20, 1923,

that I last saw him alive on Feby 20, 1923,

and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Hugh Forsythe, M. D.

, 19 (Address) 1214 E Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Cem. Carroll Co Md

DATE OF BURIAL: Feb 25 1923

20 UNDERTAKER: Wm Nicholas Sons

ADDRESS: Northern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary
Dr. H. Forsythe.
424 North Ave
Norwood 2525 W

Spec.—1-10-21—M&T—1500 Blks.

D72859

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D72859

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital ST.) WARD)

2-FULL NAME Amelia McElborn

(a) RESIDENCE No. 3503 Garrison Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: W. G. McElborn

6 DATE OF BIRTH (month, day, and year): March 23 - 1839

7 AGE: Years 83; Months; Days; If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Lyman Certz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Norman G. McElborn

(Address): 3503 Garrison Blvd

15 Filed FEB 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 21 19 23

17

I HEREBY CERTIFY, That I attended deceased from Jan 20 . 1923 . to Feb 21 . 1923 .

that I last saw her alive on Feb 21 . 1923 .

and that death occurred, on the date stated above, at 9 AM m.

The CAUSE OF DEATH* was as follows:

Carcinoma gall-bladder

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary): Myocardial insuff.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dudley P. Bowe M. D.

. 19 (Address) 704 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 2/24 1923

20 UNDERTAKER: William Cook

ADDRESS: 501 E Hoff St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72860

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72860

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Mt Winans

CITY OF BALTIMORE: (No. 2203 Washington Blvd. St.; 25 WARD)

REGISTERED No. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lillian Simmons

(a) RESIDENCE. No. 2203 Washington Blvd. St.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Simmons

6 DATE OF BIRTH (month, day, and year) July 22 - 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mt Winans

PARENTS

10 NAME OF FATHER William Kaufman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Kaufman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) George Simmons Mt Winans

15 FEB 23 1923 ROBERT N. KNAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1923, to Feb 22, 1923, that I last saw her alive on Feb 21, 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the throat.

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum.

(Signed) Raymond Adams, M. D.

Feb 22 1923 Address 4 Oakland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Country — DATE OF BURIAL: 2/27 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72861

161-001

CERTIFICATE OF DEATH.

D72861

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N Linwood Ave 6 WARD)

2-FULL NAME Baby Jones

(a) RESIDENCE NO. 158 N Linwood Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/20/23

7 AGE Years Months Days If LESS than 1 day, hrs. min.

Premature Birth 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Benjamin F. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice McClure

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant (Address) Benjamin F. Jones 158 N. Linwood Ave

15 Filed FEB 23 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20/1923

17 I HEREBY CERTIFY, That I attended deceased from 2/20/, 1923, to 2/20/, 1923, that I last saw h alive on 2/20/, 1923 and that death occurred, on the date stated above, at 10:40 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Was diagnosis confirmed by Operation or Autopsy?

What test confirmed diagnosis?

(Signed) Thomas J. Watts, M. D.

, 19 (Address) 451 E. 22nd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. DATE OF BURIAL Feb 23 1923

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Bloom

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information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72862

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D72862

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2136 Harford Ave. ST., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Schmidt

(a) RESIDENCE NO. 2136 Harford Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Andrew W. Schmidt

6 DATE OF BIRTH (month, day, and year): Oct. 30 1858

7 AGE: Years 64. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt. Md

PARENTS

10 NAME OF FATHER: Charles Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt. and.

12 MAIDEN NAME OF MOTHER: M. Reis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt. Md

14 Informant: Charles Schmidt

(Address) 2136 Harford Ave.

15 FEB 23 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 20 19 23

17

I HEREBY CERTIFY, That I attended deceased from Feb, 1921, to Feb 1923,

that I last saw h- alive on Feb 20 1923,

and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Paralysis of Bowel

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) J. W. Postlewaite M. D.

, 19 (Address) 3 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: 2/23 1923

20 UNDERTAKER: George J. Ruth

ADDRESS: 1135 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Henry M. Albers Sr

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72863 129 D72863

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1325 Hillman n

CITY OF BALTIMORE: No. ~~1325 Hill~~ ST.: 9 WARD

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry M. Albers Sr.

(a) RESIDENCE. No. 1325 Hillman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary. Albers.

6 DATE OF BIRTH (month, day and year): Nov 17/1864

7 AGE: Years 58 Months Days

10 LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Cambridge Md.

PARENTS

10 NAME OF FATHER: William Albers.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cambridge Md.

12 MAIDEN NAME OF MOTHER: Ann Adams.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge Md.

14 Informant (Address): Mary E. Albers 1325 Hillman st

15 Filed FEB 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 23

17

I HEREBY CERTIFY, That I attended deceased from Tuesday Feb. 13th 1923, to Feb. 20th, 1923, that I last saw him alive on Tuesday 13th at 11 A.M. 1923, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Heart Complication

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Cystitis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. Simpson M. D.

, 19 (Address) S. W. Cor. Eutaw & Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Feb 24 1923

20 UNDERTAKER: Grover F. Ruth — ADDRESS: 1735 Hayford Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. Every item of infor-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72864

D72864

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 415 W. Barre ST.; 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Carter

(a) RESIDENCE. NO. 415 W. Barre ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 65 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Watchman

(c) Name of employer: Merchants & Miners St.

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Henry Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Ethel Carter

(Address): 415 W Barre St.

15 Filed ..... 19..

FEB 23 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/21/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 12/13/ 19 22, to 2/21/ 19 23, that I last saw him alive on 2/20/ 19 23, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

About (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis (duration) about 6 mos. (or hr.) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical - microscopic

(Signed) J. Guy Bowley, M. D.

2/21/ 19 23 (Address) 900 S. Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: West Point. Va

DATE OF BURIAL: Feb 23 1923

20 UNDERTAKER: Jno. N. Toadvine

ADDRESS: 142 Ostend St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72865

CERTIFICATE OF DEATH.

161-001 D72865

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3403 Bank ST., 76 WARD)

2-FULL NAME Christina Schmeiser

(a) RESIDENCE No. 3403 Bank ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Christian Schmeiser

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Lydia E. Schukner

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Christian Schmeiser

(Address) 3403 Bank St

15 FEB 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1923, to Feb 22, 1923, that I last saw h[illegible] alive on Feb 22, 1923 and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Premature Foetus
6 months

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) H B Sellers M. D.

2/22, 1923 (Address) 315 S. Highland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem — DATE OF BURIAL: Feby 23 1923

20 UNDERTAKER: John Sellers & Sons — ADDRESS: 2008 Eutaw

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72866 ✓ 126 D72866

CERTIFICATE OF DEATH.

D72866

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 E Lombard ST., V WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Raymond French

(a) RESIDENCE NO. 1805 E Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Selma Meyer

6 DATE OF BIRTH (month, day, and year): Jan 14 1887

7 AGE: Years 36 Months ..... Days 7 If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED: Wire worker

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm L French

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary C Coppick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Mrs Selma French 1805 E Lombard

15 Filed FEB 23 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 20 1923

17 I HEREBY CERTIFY, that I attended deceased from Feb 19, 1923 to Feb 20, 1923 that I last saw him alive on Feb 20, 1923 and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Convulsions

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Anaemia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas H Keller M. D.

2/24/23 19 (Address) 1937 Yoncalla Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: Feby 23 1923

20 UNDERTAKER: John Dillon — ADDRESS: 208 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72867

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D72867

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.. 529 N Castle ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Fekle

(a) RESIDENCE NO.. 529 N Castle ST., WARD 7

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Fekle

6 DATE OF BIRTH (month, day, and year): Dec 31—1857

7 AGE — Years: 65 — Months: 1 — Days: 21 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Fekle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina Kesselbrenner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mary Fekle 529 N Castle St

15 Filed FEB 23 1923 ROBERT R. KNOTT, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9 1923 to Feb 20 1923

that I last saw h[illegible] alive on Feb 20 1923

and that death occurred, on the date stated above, at 12.50 p.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Acute Cholecystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pending

(Signed) [illegible] M. D.

1923 (Address) 500 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marks Cem

DATE OF BURIAL: Feby 23 1923

20 UNDERTAKER: John Dellrich

ADDRESS: 2008 Aliceanna

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

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mation should be carefully supplied. AGE should be stated EXACTLY. PHYSIC... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement... TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72868

D72868

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Homewood Apartments ST., 12 WARD)

2-FULL NAME SALLIE JANE OULD

(a) RESIDENCE NO. Homewood Apartments ST., 12 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? 78 yrs. 2 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Perry Ould

6 DATE OF BIRTH (month, day, and year) Dec-5-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	78	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Dobson

11 BIRTHPLACE OF FATHER (city or town) (State or country) East. Shore Maryland

12 MAIDEN NAME OF MOTHER Ann Belt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) East. Shore Maryland

14 Informant Mr. H. O. Brawner (Nephew)
(Address) Belle. C. Club Roland Park

15 Filed FEB 23 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922, to Feb. 21, 1923.

that I last saw h alive on Feb 21, 1923,

and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jefferson Brawner M. D.

2-24 1923 (Address) 2846 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Feb-23-23

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS: 108 W. NORTH AVE.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7-14-001

D72869

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat (St.) 28 (Ward)

2-FULL NAME Alice Lynch (Sister Louise Clare)

(a) RESIDENCE. No. Mt Hope Retreat St., 28th Ward. Hartford Conn

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 15 ds. How long in U. S., if of foreign birth? 36 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	36	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious

(b) General nature of industry, business, or establishment in which employed (or employer): Teaching

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Milford Conn.

PARENTS

10 NAME OF FATHER: Daniel Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country): (?) (?)

12 MAIDEN NAME OF MOTHER: Mary Hastings

13 BIRTHPLACE OF MOTHER (city or town) (State or country): (?) (?)

14 Informant: Records of Mt Hope Retreat

(Address): Mt Hope Retreat

15 Filed FEB 23 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb/22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 8th, 1923, to Feb 22, 1923.

That I last saw h alive on Feb 22, 1923,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy -

Post Cerebral Hemorrhage -

(duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Mania - abt (duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? Hartford Conn

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hartford Conn — DATE OF BURIAL: Feb 23 23

20 UNDERTAKER: [illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72870

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph P Jeffra

(Residence in Baltimore: No. 34 E Fyth St St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. May (Month) 7 (Day) 1847 (Year)

7-AGE.	If LESS than 1 day,
75 yrs. 8 mos. 24 ds.	....hrs. or.... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ice Cream dealer
(b) General nature of industry, business, or establishment in which employed (or employer): Confectioner & Ice Cream Mfg

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Ignatius Jeffra

11-BIRTHPLACE OF FATHER, (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Josephine Sinatra

13-BIRTHPLACE OF MOTHER, (State or Country). Italy

14-THE ABOVE IS TRUE TO THE REST OF MY KNOWLEDGE.

(Informant) Mary R. Jeffra

(Address) 34 E Fyth St

15. Filed FEB 23 1923 192.. ROBERT R. KRAUTER Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb (Month) 20 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquisition (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Chest & Internal Hemorrhage

Contusion Mobile Accident

(Duration) ....yrs. .... mos. 2 hrs

CONTRIBUTORY (Secondary) Acute Lung Trouble

(Duration) ....yrs. .... mos. 7 ds.

(Signed) James McKenlon M. D. (Coroner)

Feb 21 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ....yrs. .... mos. 7 Days In the State ....yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? Washington Rd

Former or usual residence 34 E Fyth St

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cem DATE OF BURIAL. Feb 24 1923

20-UNDERTAKER. F. A. Krause & Son ADDRESS 703 Hanover

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE ✓

D72871

CERTIFICATE OF DEATH.

90 D72871

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2003 Belair Ave ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elezabeth Matukaitis

(a) RESIDENCE No. 2003 Belair Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Noknow

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer No

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Joseph Yuskevicus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Frencis Palubinckas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Jule Mandrayckas
(Address) 24 South Freemont Ave

15 Filed FEB 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1923, to Feb 21, 1923,
that I last saw h[illegible] alive on Feb 21, 1923,
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Fatty degeneration of Heart

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) High blood pressure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hy Rud Drain, M. D.

19 (Address) 1117 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hoyl Redeemer	Feb. 24th 1923
20 UNDERTAKER	**ADDRESS**
John Grebliauckas	425 S Paca St

D72872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-001 D72872

Registered No. C.....

1-PLACE OF DEATH Pronounced Dead at Franklin Square Hospital

City of BALTIMORE: (No. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence Bury

(Residence in Baltimore: No. 1317 Scott St St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Feb (Month) 8 (Day) 1888 (Year)

7-AGE: 36 yrs. 0 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Piedmont Div.

9-BIRTHPLACE, (State or Country): Balto City

PARENTS.

10-NAME OF FATHER: David Bury

11-BIRTHPLACE OF FATHER, (State or Country): Balto Cty

12-MAIDEN NAME OF MOTHER: Margaret Kenny

13-BIRTHPLACE OF MOTHER, (State or Country): Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Bury

(Address) 1317 Scott St

15-

Filed FEB 23 1923 ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 21 (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Base & Skull
Steam R.R. accident while
walking on track

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H. Fenton M. D.
(Coroner.)

Feb 22 192 3 (Address) 702 E. Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery DATE OF BURIAL, Feb 23 19 23

20-UNDERTAKER, James Dignan & Son ADDRESS, 1008 E. Pacca St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72873

49

D72873

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3925 Clover Hill Rd ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Murrell Hopkinson

(a) RESIDENCE. NO. 3925 Clover Hill ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lillian Lewis Hopkinson

6 DATE OF BIRTH (month, day, and year) Sept 18 1857.

7 AGE: Years 65 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Dentist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

055

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Moses E Hopkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass

12 MAIDEN NAME OF MOTHER: Eliz Ann Frailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Lillian L. Hopkinson
(Address) 3925 Clover Hill Rd

15 FEB 23 1923

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 19 1923 to Feb 22 1923, that I last saw him alive on Feb 21 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Uremic or Toxic Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic examination

(Signed) M. Talbot Parlin, M. D.

Feb 23 1923 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount | DATE OF BURIAL: Feb 24 1923

20 UNDERTAKER: John O. Mitchell | ADDRESS: 120 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DO NOT WRITE OR STAMP BELOW THIS LINE—RESERVED FOR BINDING

D72874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D72874

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 912 Argyle Av ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Bratton

(Residence in Baltimore: No. 912 Argyle Ave St.; yrs. 47 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	married

6-DATE OF BIRTH, August (Month) ..., 1876 (Day) (Year)

7-AGE, 47 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) ... B. & O.

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Jas. Bratton Sr.

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER Annie Wolford

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Bratton

(Address) 912 Argyle Ave

15-

Filed FEB 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 20, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(Duration) ... yrs. ... mos. 1 ... ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart Bronchitis

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. T. J. Hennessy M. D.
(Coroner.)

Feb. 22, 1923 (Address) 2507 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Pt Lookout Cem. DATE OF BURIAL, 2/23/23, 19...

20-UNDERTAKER James Hendrickson ADDRESS 778 N Eden

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72875

CERTIFICATE OF DEATH.

100-001

D72875

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 N. Arlington Ave ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genievie Jones

(a) RESIDENCE No. 232 N. Arlington Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan. 7th. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	One #	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER William Jones

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Charlette N.C.

12 MAIDEN NAME OF MOTHER Jessie Nelson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland, Howard Co.

14 Informant Jessie Nelson
(Address) 232 N. Arlington

15 Filed FEB 23 1923 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 20th. 1923 to Feb 21 st. 1923

that I last saw her alive on 21st. 1923

and that death occurred, on the date stated above, at 3:40 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Unable to get much history

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 2/23 1923

20 UNDERTAKER J. Edward Hall

ADDRESS 1924 McCulloh

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

D72876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72876

1-PLACE OF DEATH

City of BALTIMORE: (No. 1834 Druid Hill Av St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Dennis

(Residence in Baltimore: No. 1834 Druid Hill Av St.; 77 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

8-DATE OF BIRTH: about (Month) (Day) 1845 (Year)

7-AGE: 69 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): Ont

9-BIRTHPLACE (State or Country): Md.

PARENTS:
10-NAME OF FATHER: Unknown
11-BIRTHPLACE OF FATHER, (State or Country): Unknown
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eva Chapman

(Address) 1834 Druid Hill Av

15-

Filed FEB 23 1923 ROBERT R. KRAUTH Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb. 20 (Month) (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. T. Stevenson M. D. (Coroner.)

Feb. 24 192 3 (Address) 220 E Edmondson Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL: Feb 25 19 23

20-UNDERTAKER: W. F. Dunn

ADDRESS: Baltimore

ite CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72877 ✓ D72877

D72877 CERTIFICATE OF DEATH. 162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital (ST.) 3 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hawkins

(a) RESIDENCE No. 301, S. ~~Broad~~ Bond St., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of infant.

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	0	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant. ~~boy~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Hansford Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Susie Saunders.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Johns Hopkins Hospital. (Address)

15 FEB 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923. to Feb. 15, 1923.

that I last saw ~~him~~ alive on Feb 15, 1923.

and that death occurred, on the date stated above, at 1200 m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) WW Gray, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL FEB 24 1923, 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

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D72878 HEALTH DEPARTMENT—CITY OF BALTIMORE 128 D72878

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 714 Leytonia Court St., 21 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Gormley

(Residence in Baltimore: No. 714 Leytonia Court St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH. ....., 1..... (Month) (Day) (Year)

7-AGE. 46 yrs. mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Bath Co Va

PARENTS.

10-NAME OF FATHER. Loyd Gormley

11-BIRTHPLACE OF FATHER. (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Ellen Smith

13-BIRTHPLACE OF MOTHER. (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Goss

(Address) 604 S. Eutaw St

15-

FEB 23 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 21 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

..... (Duration) ..... yrs. Don't Know mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Don't Know

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... H K Formey M. D. (Coroner.)

2-22 ..... 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn DATE OF BURIAL. Feb 24 19...

20-UNDERTAKER. J. H. Brown & Son ADDRESS 10 E. Mulberry

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72879 — 74-001 — D72879

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2606 Gulford Ave ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Corrine Hedrick

(Residence in Baltimore: No. 2606 Gulford Ave. St.; 74 yrs., 3 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ..., 1852 (Month) (Day) (Year)

7-AGE, 71 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Pa.

PARENTS.

10-NAME OF FATHER, David Christy

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace A. Hedrick

(Address) 2606 Gulford Ave

15- Filed FEB 23 1923, 191 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 22, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 21 1923, to Feb 22 1923, that I saw her alive on Feb 21 1923, and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral)

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. H. Stout M. D.

Feb 22, 1923 (Address) 1107 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Warren Baltimore Md

19-PLACE OF BURIAL OR REMOVAL, Poplar Balto Co — DATE OF BURIAL, Feb 25, 1923

20-UNDERTAKER Wm L. Brooks — ADDRESS Upshur Md.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72880

CERTIFICATE OF DEATH.

74 001

D72880

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3004 McElderry ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Gahn

(a) RESIDENCE NO. 3004 McElderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ late Ida Gahn

6 DATE OF BIRTH (month, day, and year) Feb 8-53

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo. W. Gahn

(Address) 3004 McElderry

15 Filed FEB 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1923, to Feb 22 1923

that I last saw h~~e~~ alive on Feb 22 1923

and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

1a Broncho Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) yrs. 1 mos 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) I Bernard [illegible], M. D.

, 19 (Address) 100 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 2/24 1923

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D72881 HEALTH DEPARTMENT—CITY OF BALTIMORE D72881

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 341 2 Eastern ave ST.; 76 WARD) REGISTERED NO. C 74-01

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry A Hood

(Residence in Baltimore: No. 3408 E. Pratt St St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, March 11 (Month) (Day), 1866 (Year)

7-AGE, 56 yrs. 11 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, John Hood

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lydia Hood

(Address) 407 Penna ave

15- Filed FEB 23 1923, 191 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 20th (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, au- topsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos B. Horton M. D.
(Coroner)
Feb 21st, 1923 (Address) Curtis Bay Balto. Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Carmel	2/23/23
20-UNDERTAKER Philip Herwig	ADDRESS 2016 Aliceanna St

Spec.—1-10-21—M&T—1500 Bks.

D72882

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D72882

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #28 N. 11th St., ST., N WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Brady.

(a) RESIDENCE NO. 28 N. 11th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Dont Know~~.

6 DATE OF BIRTH (month, day, and year): Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Buffer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant (Address): Mrs M. O Glasgow 28 N. 11th St. City

15 Filed FEB 23 1923, 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 22 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-18, 1923, to 2-22-, 1923, that I last saw him alive on 2-22, 1923, and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Goldberg M. D.

2-23, 1923 (Address) 2210 Linton Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dan Lawn Cemetery — DATE OF BURIAL: Feby 24-23

20 UNDERTAKER: Robt Jenner Sons — ADDRESS: W. Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72883 100-001 D72883

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Sterling St., 5 Ward)

2-FULL NAME Dorothy Mae Holland

(a) RESIDENCE NO. 607 Sterling St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE C.

5 Single, Married, Widowed, or Divorced, (write the word) S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John B. Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John B. Holland

(Address)

Filed FEB 23 1923 Registrar

Burial Permit Clerk 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 21, 1923, to Feby 22, 1923,

that I last saw her alive on Feby 22/23, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 6hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Grant L. Ley, M. D.

2/23/23 (Address) 1720 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL Feb 23 1923

20 UNDERTAKER Edward Bros ADDRESS 1631 Orleans

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72884 11-001 D72884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 Hemmeman St., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elston Banks

(a) RESIDENCE NO. 1908 Hemmeman ST., 8 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Aug 1922

7 AGE: Years — Months: 6 — Days: 2 — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Elige Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Thelma Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Thelma Coleman 1921 Division Ave.

15 Filed FEB 23 1923, 19.. ROBERT P. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1923, to Feb. 20, 1923, that I last saw h[illegible] alive on Feb. 20, 1923, and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows: Capillary Bronchitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. C. Robinson, M. D.

2/23 1923 (Address) 1520 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Laurel cemetery

DATE OF BURIAL: Feb 23 1923

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 Oleander

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72885 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 171 D72885

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 3 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Antoni Lazarowicz

(Residence in Baltimore: No. 810 S. Bond St. 4 yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
male	white	Married

6-DATE OF BIRTH. unknown ..... 1..... (Month) (Day) (Year)

7-AGE. 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer): 004

9-BIRTHPLACE. (State or Country). Poland

PARENTS.

10-NAME OF FATHER. John Lazarowicz

11-BIRTHPLACE OF FATHER. (State or Country). Poland

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER. (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stella Lazarowicz (wife.)

(Address) 810 S.Bond

15- FEB 23 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb.22/23 ....., 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held un inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage- Throat cut by razor. (Wound self inflicted)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) yrs. 4 mos. ds.

(Signed) J. S. H. Potter M. D. (Coroner.)

2/22/23 192 (Address) 508 E. North

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary

DATE OF BURIAL. Feb 24 1923

20-UNDERTAKER. William Fralfsky

ADDRESS 1618 Eastern Ave.

state CAUSE OF DEATH in plain terms, so that it may be is very important. See instructions on back of certificate.

D72886

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D72886

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 723 School St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... James Arthur Mullen

(Residence in Baltimore: No. 723 School St.; yrs. 7 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	single

6-DATE OF BIRTH. July 5, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 7 mos. 14 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Md.

PARENTS

10-NAME OF FATHER, Geo. Mullen

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Eliz. Chase

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eliz. Mullen

(Address) 723 School St

15-

Filed FEB 23 1923 '22 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 22, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) none known

(Duration) ....yrs. ....mos. ....ds.

(Signed) Dr. T. Hennessy M. D. (Coroner.)

Feb. 22 1923 (Address) 248 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Feb. 25 1923
20-UNDERTAKER,	ADDRESS
John M Johnson	1234 Eutaw

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72887

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72887

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: No. St. Joseph's Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Radcliffe

(a) RESIDENCE. NO. 1117 Druid Hill Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gibson Co N. C.

PARENTS

10 NAME OF FATHER Ransom Radcliff

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Carrie Brooks 1125 Druid Hill Ave

15 FEB 23 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22, 1923

17 I HEREBY CERTIFY, That I attended deceased from February 13 1923, to Feb. 22, 1923, that I last saw him alive on Feb. 21, 1923, and that death occurred, on the date stated above, at 2 30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Kruger, M. D.

, 19 (Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gibson Co. N. C.

DATE OF BURIAL Feb 25 1923

20 UNDERTAKER George H. Holland

ADDRESS 1631 Division

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—11. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72888 D72888

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 401 East Lynn St. 20th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian F. Koch

(a) RESIDENCE. No. 401 East Lynn St. 20th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Koch

6 DATE OF BIRTH (month, day, and year) April 2nd 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Mrs Wilkins Co Paper factory

(c) Name of employer Mrs Wilkins Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Koch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Koch
(Address) 401 E. Lynn St.

15 Filed FEB 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1923, to Feb 22, 1923;

that I last saw h[illegible] alive on Feb 22, 1923;

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Ules - Colitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) H. A Knell, M. D.

2/23, 1923 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 24

20 UNDERTAKER	ADDRESS
F. B Keppert	2236 Fredk Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72889

129 D72889

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 N. Fort ave ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. West

(a) RESIDENCE. No. 138 W. Fort ave ST.: 23 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4/1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel West

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Masterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. West.
(Address) 138 W Fort.

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

FEB 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1923, to Feb 21, 1923, that I last saw h[illegible] alive on Feb 20 1923 and that death occurred, on the date stated above, at 5-40 P m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) about 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis about 5 yrs. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & C.

(Signed) C Baum, M. D.

, 19 (Address) 125 Hanover St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL 2/24 1923

20 UNDERTAKER L. F. McCulla

ADDRESS 130 Fort

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72890

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72890

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Groce

(a) RESIDENCE NO. 12 So. Register ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Feb. 10 1880

7 AGE 43 Years — Months — Days If LESS than 1 day, ... hrs. or .. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Eleven Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimo

12 MAIDEN NAME OF MOTHER Margaret Butler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Wm. Groce (Address) 12 S Register

15 Filed FEB 23 1923 19 ROBERT H. KRAUSE Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-20-1923

17

I HEREBY CERTIFY, That I attended deceased from 2-7-, 1923, to 2-20-, 1923,

that I last saw ~~him~~ alive on 2-20-, 1923

and that death occurred, on the date stated above, at 12 10 P. m.

The CAUSE OF DEATH* was as follows:

Papillary cystoma of Ovaries - mets to Liver

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) general peritonitis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2/7/23

Was there an autopsy? no

What test confirmed diagnosis? Op. Findings

(Signed) Newton S. Carr, M. D.

2/20/1923 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arbutus Cemetery — DATE OF BURIAL Feb 23. 1923

20 UNDERTAKER Mrs Robert + Elliott — ADDRESS 1725 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malignant

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72891 D72891

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. 5

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 260 Colonn ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John De Shields

(a) RESIDENCE. NO. 260 Colonn ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 5/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
5/	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oyster Shucker

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer: Robinson

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Julia De Shields
(Address) 260 Colonn

15 Filed . 19 . ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

FEB 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-20- 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1923, to Feb 20, 1923, that I last saw h[illegible] alive on Feb 19, 1923, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos 23 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W Clyde Burns, M. D.

2-22, 1923 (Address) 2102 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ever Green Cemetery

DATE OF BURIAL: Feb. 23 1923

20 UNDERTAKER: Mrs. R. C. Elliott

ADDRESS: 1723 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72892

CERTIFICATE OF DEATH.

100-001 D72892

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr William E. Wyatt

(Residence in Baltimore: No. 2903 W. Lanvale St.; ..... yrs., 8 mos. ..... ds.)

R. R.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, June (Month) 9 (Day), 1861. (Year)

7-AGE, 61 yrs. 8 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Meat Packer
(b) General nature of industry, business, or establishment in which employed (or employer): Armour Packing Co

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, William E. Wyatt

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Chandler

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian E. Wyatt

(Address) 809 Park Ave

15-

FEB 23 1923 191 ROBERT R. KRAUTER, Burial Permit Clerk. (Registrar.)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 22 (Month) (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1923, to Feb 22 1923, that I saw h[illegible] alive on Feb 22 1923, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

.....

Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James E. Gibson M. D.

2/24, 1923 (Address) Md. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 4 ds. In the State 61 yrs. 8 mos. 13 ds.

Where was disease contracted, if not at place of death? 2903 W. Lanvale

Former or usual residence ..... " "

19-PLACE OF BURIAL OR REMOVAL, Western Cem DATE OF BURIAL, Feb 24, 1923

20-UNDERTAKER Mrs Mrs. J. W. Templeton & Son ADDRESS 501 W. Fayette St

ROBERT R. KRAUTER, Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

D72893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72893

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2928 E. Fayette ST., 6 WARD)

2-FULL NAME Clementine Fleckenschildt.

(a) RESIDENCE No. 2928 E. Fayette ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Henry W. Fleckenschildt

6 DATE OF BIRTH (month, day, and year) Aug. 30th 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Johann.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Adler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Fleckenschildt (Address) 2928 E Fayette St

15 Filed FEB 23 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21st 1923

17 I HEREBY CERTIFY, ~~That I~~ attended deceased from Feb 12, 1923, to Feb 21, 1923, that I last saw h~~er~~ alive on Feb 21, 1923 and that death occurred, on the date stated above, at 12 40 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? — No

What test confirmed diagnosis? —

(Signed) John S. Owens M. D.

Feb 22, 1923 (Address) 354 Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Feb 26 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	400 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D72894

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1129 W. Lombard

CITY OF BALTIMORE: (No.) ~~James~~ Clark ST.: ~~18~~ (WARD)

2-FULL NAME James Clark

(a) RESIDENCE. No. 1129 W. Lombard ST., 18 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 months ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 21 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.
Premature birth		5½ months		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt. Md

PARENTS

10 NAME OF FATHER Samuel Pierpoint Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md

12 MAIDEN NAME OF MOTHER Ida Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant Ida Reynolds Clark

(Address) 1129 W. Lombard St.

15 FILED FEB 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1923, to Feb 21, 1923, that I last saw h[illegible] alive on Feb 21, 1923, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) S. H. Hayden, M. D.

, 19 (Address) 8371 Pleasant St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 23 19 23

20 UNDERTAKER John J. Fields ADDRESS 1200 W. Lombard

MARK PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72895

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D72895

CERTIFICATE OF DEATH.

(PLACE OF DEATH

CITY OF BALTIMORE (No. 246, So. Durham ST. 7 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-FULL NAME Marion Druk

(Residence in Baltimore: No. 246 So Durham St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb 21st, 1923
(Month) (Day) (Year)

7-AGE 0 yrs. 0 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Walter Druk

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Frances Casper

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Druk

(Address) 246 So. Durham St

15- FEB 23 1923

Filed....., 191... ROBERT B. KRAUTER, Burial Permit Clerk.....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 22, 192...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

a Premature Birth

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Thos. H. Norton M. D.
(Coroner)

Feb 23 1923 (Address) Curtis Bay Md

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Feb 23, 1923

20-UNDERTAKER John A Weber

ADDRESS 1803 Bank St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72896

CERTIFICATE OF DEATH.

b 101-001 D72896

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 25 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Keyser

(a) RESIDENCE NO. Washington Boulevard (St.) Halethorpe (Ward) .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Keyser

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: 28 Years — Months — Days — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): [illegible]

PARENTS

10 NAME OF FATHER: Edward C Keyser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs Mary C. Keyser
(Address) Washington Blvd. Halethorpe

15 Filed FEB 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1923, to Feb 23, 1923,
that I last saw him alive on Feb 23, 1923,
and that death occurred, on the date stated above, at 5.50 Am m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Failure Pulmonary Edema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W C Caldwell, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: 2/26/23

20 UNDERTAKER: Mrs Addie Walker — ADDRESS: 723 N Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72897 D72897

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 15 WARD)

2-FULL NAME Elizabeth Titus

(a) RESIDENCE NO. 1466 N. Carey St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of Jacob Titus

6 DATE OF BIRTH (month, day, and year) ? ? Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
about 21	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland,

PARENTS

10 NAME OF FATHER: Fred Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Hospital Records

15 Filed , 19 Robert P. Harrison, Registrar

Burial Permit Clerk

B 23 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-22 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-13 , 1923 , to 2-22 , 1923.

that I last saw her alive on 2-22 , 1923,

and that death occurred, on the date stated above, at 9.15 p.m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. 3 ds. Lupus Septicemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? about address

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Findings

(Signed) J. Norwood Wilson, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Point Md

DATE OF BURIAL: 2/24 1923

20 UNDERTAKER: William Cook

ADDRESS: 502 E North

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72898

CERTIFICATE OF DEATH.

74-001 D72898

1-PLACE OF DEATH Foster yes

CITY OF BALTIMORE: (No. 1st Winans ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolphe A Diersyon

(a) RESIDENCE NO. Foster ave 1st Winans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 4 mos. 26 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida V. Diersyon

6 DATE OF BIRTH (month, day, and year) Sept 26 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	47	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (40)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pikesville Md

PARENTS

10 NAME OF FATHER Gustave Diersyon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anderson Feb 23, 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theodore Diersyon

(Address) 146 N Carey St

15 B 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1925

17 I HEREBY CERTIFY, That I attended deceased from Nov 1922, to Feb 22 1925, that I last saw him alive on Feb 22 1925, and that death occurred, on the date stated above, at 1.20 p m.

The CAUSE OF DEATH* was as follows:

Psoriasis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) 20 yrs 1/2 mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Raymond P. Hodges M. D.

(Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	Feb 24 1925
20 UNDERTAKER	ADDRESS
P Solomon & Son	Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72899 ✓ 15 D72899

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Barrett

(a) RESIDENCE No. 930 Greenmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
78	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseshoer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Thomas Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine O'Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Municipal Hospital Records.

(Address)

15 Filed FEB 23 1923, 19 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 19 23

17

I HEREBY CERTIFY, That I attended deceased from January 18, 19 23, to February 21 19 23.

that I last saw him alive on February 20, 19 23.

and that death occurred, on the date stated above, at 7:00 A.M. m.

The CAUSE OF DEATH* was as follows:

Frost bite Gangrene

(Infected) (Acute)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of 2/19/23

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Clyde Mowell M. D.

2-21 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: Feb 24 1923

20 UNDERTAKER: William G. Schaeffer — ADDRESS: 1816 Monument

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72900 D72900

CERTIFICATE OF DEATH.

Registered No. C 179

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Ethel P Phebus

(Residence in Baltimore: No. 332 W 21st St St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

6-DATE OF BIRTH: October 11, 1916 (Month) (Day) (Year)

7-AGE: 6 yrs. 4 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Maryland.

PARENTS:

10-NAME OF FATHER: Arthur Phebus

11-BIRTHPLACE OF FATHER, (State or Country): Frederick, Md

12-MAIDEN NAME OF MOTHER: Lillie White

13-BIRTHPLACE OF MOTHER, (State or Country): Frederick, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Phebus

(Address) 332 W 21st St.

15- Feb 23 1923 Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 22 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

2 & 3° Burns of front of body & legs, by clothes caught fire from Gas Stove accident

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) to Pneumonia

(Duration) yrs. mos. 1 ds.

(Signed) James M Denton M. D. (Coroner.)

Feb 22 1923 (Address) 7 or E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. 1 ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence 332 W 21st St

19-PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Feb 26, 1923

20-UNDERTAKER: E. LeRoy Stiffler

ADDRESS: 125 E. North Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72901

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72901

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3350 Strickland ST., 20 WARD)

2-FULL NAME Marie F Woody

(a) RESIDENCE No. 3350 Strickland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank L Woody

6 DATE OF BIRTH (month, day, and year) Feb 27 1895

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
27	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ernest L Troyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Laura Rittenhouse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm L Troyer
(Address) 3350 Strickland st

15 Filed 2 23 1923 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1923, to Feb 21, 1923, that I last saw h[illegible] alive on Feb 21, 1923, and that death occurred, on the date stated above, at 4.15 p.m.

The CAUSE OF DEATH* was as follows:

Uterus Tubo Ovarian Carcinoma

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

2.23 (Address) 222 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL 2/24/23

20 UNDERTAKER George A Talley ADDRESS Fulton & Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72902

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72902

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 10 Annapolis ave St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Frank P. Maley

(Residence in Baltimore: No. 10 Annapolis ave St.; yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. colored

5-Single, Married, Widowed, or Divorced, (Write the word.) widower

6-DATE OF BIRTH. Oct (Month) 15 (Day) 1832 (Year)

7-AGE. 91 yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Iron
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Wellington Del

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country) unknown

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country) unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L. Colbert

(Address) 10 Annapolis ave

15- Robert P. Harrison, 192.....

2 1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb (Month) 22 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(Duration) yrs. mos. ds.

(Signed) James M Benton M. D.
(Coroner)

Feb 22 1923 (Address) Just Chas St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Druid Cemetery — DATE OF BURIAL. Feb 24 1923

20-UNDERTAKER. Geo. Lee Hooper — ADDRESS 406 N Conkling

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72903 D72903

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5009 Park Heights St., 27 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Kroeger

(a) RESIDENCE No. 5009 Park Heights St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Kroeger

6 DATE OF BIRTH (month, day, and year) Dec 3-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Fred. C. H. Kroeger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaretha A. Raabe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kiel Ger.

14 Informant Mr. Robt W. Kroeger (Address) 218 Cedar Ave Pimlico

15 Filed FEB 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22, 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 15, 1923 to Feb 22, 1923,

that I last saw h... alive on Feb 22, 1923,

and that death occurred, on the date stated above, at 10.40 A m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) — yrs. — mos 9 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) C. J. Emerson M. D.

2-22-1923 (Address) 5016 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine DATE OF BURIAL Feb 24 1923

20 UNDERTAKER Wm. Richardson ADDRESS Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D72904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 11-001 D72904

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 St. Paul ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Worrell

(a) RESIDENCE NO. 1109 St. Paul ST., WARD

(Usual place of abode)

(If non-resident give city or town and State) Springfield Mo

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 3-1873

7 AGE: Years 49 Months 9 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mo

PARENTS

10 NAME OF FATHER W. H. Worrell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mo.

12 MAIDEN NAME OF MOTHER Sophia Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mo.

14 Informant W. J. TICKNER AND SONS

(Address) NORTH & PENNS. AVE

15 Filed , 19 Robert F. Carman, Burial Permit Clerk Registrar

FEB 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1923, to Feb 22, 1923, that I last saw he alive on Feb 22, 1923, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Ralph S Hoyt, M. D.

, 19 (Address) 116 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Springfield. Mo

DATE OF BURIAL: Feb 24 1923

20 UNDERTAKER: Wm J Tickner & Sons

ADDRESS N. Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Wojciechowski) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72905 D72905

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 110 S Wolfe ST., V WARD)

2-FULL NAME Stanislaus Wojciechowski

(a) RESIDENCE NO. 620 S Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 20-1856

7 AGE — Years: 66 Months: 5 Days: 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER George Wojciechowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Catherine Wloderch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Joseph J Wojciechowski

(Address) 110 S Wolfe St

15 Filed . . 19 ROBERT F. [illegible], Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/21/— 1923 to 2/22/— 1923, that I last saw h— alive on 2/22/23 1923 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Antigua M. D.

. 19 (Address) 2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: Feb 24 1923

20 UNDERTAKER: John M Weber — ADDRESS: 1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72906

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72906

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2012 St Paul St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Hergenemus

(Residence in Baltimore: No. 2012 St Paul St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

6-DATE OF BIRTH: about 61 yrs (Month) (Day) (Year)

7-AGE: About 61 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): city

PARENTS.

10-NAME OF FATHER: Louis Woerner

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Md

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fr Julius Hergenemus

(Address) 2012 St Paul st

15-

Filed ..... 1923 .....

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb 25 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis
Disease of Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Louis Woerner M. D.
(Coroner.)

Feb 27 1923 (Address) 1631 Boland ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Bolt Cemetery — DATE OF BURIAL: Feb 26 1923

20-UNDERTAKER: H J Wichmer & Son — ADDRESS: Northern

2 1923

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72907 D72907

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 Druid Hill Ave. ST., 14th WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs H. Lee

(Residence in Baltimore: No. 2225 Druid Hill Ave. S. C., 46 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... (Month) ..... (Day), 1877 (Year)

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)..... Principal Pub. Sch.

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, Samuel See

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Mary Payne

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estelle See

(Address) 2225 Druid Hill Ave.

15-

Robert P. Harrison,

Filed ....., 191.....

Registrar.

B 24 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 21, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 10 1923, to Feb. 21 1923, that I saw h[illegible] alive on Feb. 21 1923, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) [illegible] M. D.

Feb. 22 1923 (Address) 5 E. Mt. Vernon Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn — DATE OF BURIAL. Feb. 24 1923

20-UNDERTAKER Jno W. Joadem — ADDRESS 1412 N. Eutaw St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72908

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 W. Saratoga ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Keenan

(a) RESIDENCE. NO. 2018 W. Saratoga ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Keenan

6 DATE OF BIRTH (month, day, and year) Apr 28, 1872.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Edward Dowd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Bonner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mrs Sarah A. Firmin. 2018 W. Saratoga St.

15 FEB 24 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1923, to Feb 21, 1923, that I last saw her alive on Feb 21, 1923, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Martha E Kuckeman, M. D.

2-23 1923 (Address) 2002 N Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Febry 24 1923

20 UNDERTAKER: M. J. Cowan & Son / M. J. Cowan

ADDRESS: 501 Baltimore St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72909

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72909

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 S Fulton Ave ST., 19 WARD)

2-FULL NAME Mrs Catherine Hall

(a) RESIDENCE NO. 125 S Fulton Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James V. Hall

6 DATE OF BIRTH (month, day, and year) May 13 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md (State or country)

PARENTS

10 NAME OF FATHER Patrick O'Mara

11 BIRTHPLACE OF FATHER (city or town) Limerick Co. (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Hanley

13 BIRTHPLACE OF MOTHER (city or town) Cork (State or country) Ireland.

14 Informant Mr Jas V. Hall

(Address) 125 S Fulton Ave.

15 Filed 2 24 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1923, to Feb 22, 1923,

that I last saw her alive on " " , 19 23

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw J Coughlan, M. D.

2/24, 19 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Feb 26 1923
20 UNDERTAKER John J Cowan & Son.	ADDRESS
Per J. J. Cowan	901 Hollins St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 D72911

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2089 Woodberry Ave WARD 12)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A Stine

(a) RESIDENCE No. 2089 Woodberry Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
F	W	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER H.F. Stine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Marie Mulligan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry F. Stine

(Address) 2089 Woodberry Ave

15 Filed FEB 24 1923 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 8th 1923 to Feb. 23 1923.

that I last saw h alive on Feb 23 1923,

and that death occurred, on the date stated above, at 1120 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

3 wks Co

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H.H. Wantz M. D.

2-23-23 19 (Address) 865 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Charles Pikes — DATE OF BURIAL: Feb 24 19 23

20 UNDERTAKER: Chenowith Son — ADDRESS: Chestnut Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72911

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D72911

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 Peach alley St. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Taylor

(a) RESIDENCE NO. 903 Peach alley WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/17/22

7 AGE — Years: — Months: 2 — Days: 8 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Balto. (State or country) md.

PARENTS

10 NAME OF FATHER Chas Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Beatrice Collins

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) md.

14 Informant Beatrice Taylor

(Address) 903 Peach Alley

15 Filed AUG 24 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/22, 1923, to 2/22, 1923

that I last saw living on 2/22, 1923

and that death occurred, on the date stated above, at 8:30 p m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mal Nutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Jackson, M. D.

2/23, 1923 Address) 760 W Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. — DATE OF BURIAL: 2/23 1923

20 UNDERTAKER: Robt. L. Parham — ADDRESS: 220 W Hamburg St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72912 D72912

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2360 Wilkens ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert A Hoelke

(a) RESIDENCE. NO. 2360 Wilkens ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 3 — Months: 6 — Days: 26. — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Walter Hoelke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Rose Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Walter Hoelke
(Address) 2360 Wilkens av

15 Filed: 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 23 1923

17 I HEREBY CERTIFY, That I attended deceased from February 19, 1923, to February 23, 1923, that I last saw him alive on February 23, 1923, and that death occurred, on the date stated above, at 11 20 a m.

The CAUSE OF DEATH* was as follows:

Convulsions Diphtheria

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert A C Hoelke, M. D.

2/24, 1923 (Address) 215 Walbrook ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Agnes

DATE OF BURIAL: Feb 28 1923

20 UNDERTAKER: John J Fallo

ADDRESS: 1700 W Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

24 1923

D72913 HEALTH DEPARTMENT—CITY OF BALTIMORE D72913

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 627 S. Port St. 1 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Joseph Sippel.

(Residence in Baltimore: No. 627 S. Port St.; yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, Feb. 8 (Month) (Day), 1879 (Year)

7-AGE, 44 yrs. mos. 12 ds.

If LESS than 1 day, hrs. or mins.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER, George Sippel.

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Magdelena Eberhardt

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Magdelena Sippel.

(Address) 627 S. Port St.

15- FEB 24 1923 Robert P. Barnes, 191

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 22 (Month) (Day), 1913 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. ds.

(Signed) Wm. C. Bodes M. D.
(Coroner.)

Feb 23 191... (Address) 743 E. Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, Feb. 26, 1923

20-UNDERTAKER Lilly & Zeiler ADDRESS 4038 Avon Ave

Spec.—1-10-21—M&T—1500 Blks.

D72914

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72914

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Bond

(a) RESIDENCE No. 5th Ave., Colgate, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Wdiwoed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
39	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Eugene Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto., Md.

12 MAIDEN NAME OF MOTHER: Lenora Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto., Md.

14 Informant (Address): Municipal Hospital Records.

15 Filed FEB 24 1923, 19 — Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 20 1923

17

I HEREBY CERTIFY, That I attended deceased from November 20, 1922, to February 20 1923, that I last saw him alive on February 20, 1923, and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Hypernephroma 8 mos

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) Clyde Mabee, M. D.

2-21 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery.

DATE OF BURIAL: Feb 24 1923

20 UNDERTAKER: Lilly Zeiler

ADDRESS: 4033 W. Wsh

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Fuiss organ Involved
Kidney

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72915

D72915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3205 E Fairmount St., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Searles

(a) RESIDENCE NO. 3205 E. Fairmount St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Searles

6 DATE OF BIRTH (month, day, and year): June 23-1844

7 AGE: Years 78 Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ontario

PARENTS

10 NAME OF FATHER: Wm. Forsyth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ontario

12 MAIDEN NAME OF MOTHER: Rebecca Moffit

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Jersey

14 Interment (Address): Ida Hochstedt 3103 Greenmount ave

15 Filed FEB 27 1923, 19 Robert F. Harriman Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1923 to Feb 22 1923

that I last saw h[illegible] alive on Feb 21 1923

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) 2 yrs. 6 mos ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) F. C. Bladel M. D.

(Address) 1436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: 2/24 1923

20 UNDERTAKER: J. J. Moran

ADDRESS 3000 E. Baltimore St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D72916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 D72916

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Myers

(a) RESIDENCE NO. 235 Forest St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	48	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) O & O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Albert Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER J. Chester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records. (Address)

15 Filed FEB 24 1923, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1923, to February 22 1923.

that I last saw him alive on February 21, 1923.

and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Tbc. Meningitis of both feet

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Infection in feet

(duration) yrs. 12 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

2-22-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lamed — DATE OF BURIAL 2/24 1923

20 UNDERTAKER J. Hussebaugh — ADDRESS 2620 Ord and

FEB 24 1923

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72917

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72917

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 4 St., 66 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John Sullivan

(Residence in Baltimore: No. not known St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
M	W.	

6-DATE OF BIRTH.

..... 1.....
(Month) (Day) (Year)

7-AGE. 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer). 440

9-BIRTHPLACE, (State or Country). \

PARENTS.

10-NAME OF FATHER. \

11-BIRTHPLACE OF FATHER, (State or Country). \

12-MAIDEN NAME OF MOTHER. \

13-BIRTHPLACE OF MOTHER, (State or Country). \

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed FEB 24 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 18 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquisition (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. 5 mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) 7 yrs. mos. 1 ds.

(Signed) Geo Edward Blackstone M. D.
(Coroner.)

Feb 23 1923 (Address) 1432 Bond

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
	 19
20-UNDERTAKER,	ADDRESS

JOHNS HOPKINS HOSPITAL
(Commissioner Health.)
FEB 23 1923

state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

D72918

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72918

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Lovering House St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Gillen

(Residence in Baltimore: No. Fayette E Front St. St.; yrs. mos. ds.)

Burgh

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M	W.	

6-DATE OF BIRTH.

..... 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
60 yrs. mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country).

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15 Robert P. Harrison,

Filed 192.....

B 2 4 1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 8, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary T.B.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo Chas Ross M. D.
(Coroner.)

Feb 16 192.... (Address) 143 No Bway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL. DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS. FEB 23 1923

THE MORGUE.

(Commissioner of Health.)

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D72919

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72919

CERTIFICATE OF DEATH.

161-04

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1609 N. Carey St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Ruby Dorsett

(a) Residence No. 1609 N. Carey St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. Wht

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 23/23

7-AGE. ....yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or 15 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) 1609 N Carey St (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER. Jno. F. Dorsett

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country),

12-MAIDEN NAME OF MOTHER. Vida Nadolski

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country).

11- (Informant) Mrs Violet Dorsett

(Address) 1609 N. Carey St

15- Filed 192 Robert F. Barnhart, Registrar.

Burial Permit Clerk

FEB 24 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 23/23

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 23 to Dec 23 23

That I last saw him alive on Dec 23 23

and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Congenital 5 hrs
Foetus,

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ....Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ed Schmidt M. D.

May 23 23 (Address) 1605 N Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL FEB 23 1923

UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

(Johns Hopkins Hospital.)

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72920

CERTIFICATE OF DEATH.

129 D72920

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1444 N Gay ST.: 8 WARD)

2-FULL NAME Mamie King

(a) RESIDENCE. No. 1444 N. Gay ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 11- 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Married

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Gerhardt Haufstrauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Virginia Thacker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Geo Mosser

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

B 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-23- 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9th, 1923, to Feb 23, 1923, that I last saw her alive on Feb 23, 1923 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms & signs

(Signed) Dr Alice Miller, M. D.

19 (Address) 1506 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 26 1923
20 UNDERTAKER Geo Mosser	ADDRESS 1444 N Gay

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

U. S. WHITE LEAD, WITH LINSEED OIL—THIS IS A PERMANENT RECORD.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72921

CERTIFICATE OF DEATH.

45 D72921

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3531 Liberty Heights St., Av. 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles N. Alexander

(a) RESIDENCE NO. 3531 Liberty Heights St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma L. Alexander

6 DATE OF BIRTH (month, day, and year) Sept. 28 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	43	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Amos A. Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna C. Foulke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Anna C. Alexander
(Address) 3531 Liberty Heights

15 Filed FEB 24 1923, 19 Robert F. Garrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1923, to Feb. 22, 1923, that I last saw h[illegible] alive on Feb. 22, 1923, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis (duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum (duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Nov 1922

Was there an autopsy? (Yes)

What test confirmed diagnosis?

(Signed) Thos Glover M. D.

2/24/23 (Address) 3401 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Orem Cemetery

DATE OF BURIAL 2/25 1923

20 UNDERTAKER J. Fenn Mc Gauley

ADDRESS 130 E. Fort

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72922 JOHNS HOPKINS HOSPITAL. 90 D72922

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ben Putney

(a) RESIDENCE No. 511 N. Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1, 1873

7 AGE — Years: 49 — Months: 5 — Days: 21 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Deck Builder

(b) General nature of industry, business, or establishment in which employed (or employer): Deck Builder

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Thelmer N C ~~Maryland~~

PARENTS

10 NAME OF FATHER: Nat Putney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Thelmer N C

12 MAIDEN NAME OF MOTHER: Charlott Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 Filed FEB 24 1923 Robert E. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 14 1923 to Feb 22 1923, that I last saw him alive on February 22, 1923, and that death occurred, on the date stated above at 5 20 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R Bugg, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Thelmer N C Holafax Co — DATE OF BURIAL: Feb 24 1923

20 UNDERTAKER: Mrs Robert E Elliott — ADDRESS: 1725 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history
Wassermann
negative

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72923

CERTIFICATE OF DEATH.

179

D72923

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3308 Toone ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen V. LeBrun

(a) RESIDENCE No. 3308 Toone ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. LeBrun

6 DATE OF BIRTH (month, day, and year) June 4-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kent Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Edw. Rollison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co., Md.

12 MAIDEN NAME OF MOTHER Isabelle Simpson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hartford Co. Md.

14 Informant Geo. A. LeBrun

(Address) 3308 Toone St

15 Filed 19 Robert F. Harrison Registrar

Earl J. Terrell Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 22d 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1923, to February 22 1923, that I last saw her alive on February 22, 1923, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

1 hour

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) F. B. Bronnstrup, M. D.

2-24, 1923 (Address) 3037 Odonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Feby 26 1923

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eager St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2 24 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72924 38 D72924

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 ~~503~~ N. Parrish St. ST., 19 WARD)

2-FULL NAME William Jones

(a) RESIDENCE NO. 501 ~~503~~ N. Parrish St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) May, 12th. 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Contract work

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Martha Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Martha Braxton (Friend)

(Address) 503 N. Parrish

15 Filed FEB 24 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21-'23 19

17

I HEREBY CERTIFY, That I attended deceased from Feb. 9th. , 1923 , to Feb. 21st. , 1923 ,

that I last saw him alive on Feb. 21st , 1923 ,

and that death occurred, on the date stated above, at 5:15 p.m.

The CAUSE OF DEATH* was as follows:

Acct. Parenchimatous Nephritis

(duration) ..... yrs. ..... mos. 14days

CONTRIBUTORY (Secondary) Mitral Ins.

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL Feb 24, 19 23

20 UNDERTAKER Jos. H. Dennis ADDRESS 1307 Eastern

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Syphilis

D72925 D72925

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4619 Eastern ave ST.: 76 WARD)

REGISTERED NO. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances R. Bound

(Residence in Baltimore: No. 4619 Eastern Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 15, 1922 (Month) (Day) (Year)

7-AGE, 0 yrs. 5 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

8-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, A. Bound

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Rachael Wilhelm

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Bound

(Address) 4619 Eastern Ave

15-

Filed Feb 24 1923 Robert F. Hartman Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 23rd, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(Duration) 4 yrs. 4 mos. 1 hour

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

(Signed) Wm B Norton M. D.
(Coroner)

Feb 23rd 1923 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Zion Balto Co

DATE OF BURIAL, Feby 25, 1923

20-UNDERTAKER John Dellert

ADDRESS 2008 Bleam

B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72926

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72926

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1307 Harlem Ave. St., 16 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E, Miles

(Residence in Baltimore: No. 1307 Harlem Ave. St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. December (Month) (Day) 1863 (Year)

7-AGE. 69 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Broker
(b) General nature of industry, business, or establishment in which employed (or employer): 86

9-BIRTHPLACE. (State or Country). Sommerset Co. Md.

PARENTS.

10-NAME OF FATHER. Isaac Miles

11-BIRTHPLACE OF FATHER. (State or Country). Sommerset Co.Md.

12-MAIDEN NAME OF MOTHER. Caroline Hood

13-BIRTHPLACE OF MOTHER. (State or Country). Sommerset Co.Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Florence Coulbourn

(Address) 1307 Harlem Ave.

15-

Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 22nd (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) hrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. C. T. Hennessey, M. D. (Coroner.)

Feb. 22 192 3 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	Feb 24 192 3

20-UNDERTAKER. Joseph L. B. Cook ADDRESS 1003 N. Gates St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2 24 1923

Spec. 6-9-19 H. P. Co. 1000 Blks.

D72927

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D72927

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 740 Bradley ST. 17 WARD)

2-FULL NAME Annie E Cornish

(a) RESIDENCE. No. 740 Bradley ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mns. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE 53 Years ... Months ... Days. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) House Work 790

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Cornish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Annie Cornish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Daughter Laura Cornish 740 Bradford St

15 Filed ... Robert F. Carman Registrar

Burial Permit Clerk.

B 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 19, 1923, to Feb 22, 1923, that I last saw her alive on Feb 22, 1923, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H K Cassey M. D.

. 19 (Address) 753 George St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Feb 26, 1923

20 UNDERTAKER: Mrs Robert A Elliott — ADDRESS 1725 Oakland Ave

Mention should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D72928

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72928

CERTIFICATE OF DEATH.

159-003

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 Emadison Av ST., 7 WARD)

2-FULL NAME Baby Perry

(a) RESIDENCE NO. 1818 Emadison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Sylvester Wm Perry

11 BIRTHPLACE OF FATHER (city or town) Jersey City (State or country) N. Jersey

12 MAIDEN NAME OF MOTHER Mildred Pagel

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant S. W. Perry (Address) 1818 Emadison Av

15 Filed 2 4 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1923, to Feb 24, 1923, that I last saw h alive on Feb 24, 1923, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Enlarged Thymus —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes —

What test confirmed diagnosis?

(Signed) Harry Goodman M. D.

, 19 (Address) 2306 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 2/24 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Nor

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Congenital malformation

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72929 38 D72929

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Municipal Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Timothy Green

(a) RESIDENCE NO. 126 S. Dallas St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
78	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Timothy Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records

(Address)

15 Filed ... 19 Registrar

FEB 24 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 19 23

17 I HEREBY CERTIFY, That I attended deceased from January 22, 19 23, to February 19 19 23, that I last saw him alive on February 18, 1923, and that death occurred, on the date stated above, at 3:35 A.M. The CAUSE OF DEATH* was as follows:

Aortic Insufficiency
(Syphilitic)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertrophy of Heart

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Clyde Snow M. D.

2-19-19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

FEB 2 - 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72930

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D72930

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Kirkwood

(a) RESIDENCE NO. 2104 N. Calvert St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Kirkwood

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Anna Upey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Eastern Shore, Md.

14 Informant Municipal Hospital Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ...
Registrar

B 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1923

17

I HEREBY CERTIFY, That I attended deceased from February 19, 1923, to Feburary 21, 1923, that I last saw him alive on February 20, 1923, and that death occurred, on the date stated above, at 5:05 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Mavel, M. D.

2-21-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ... 19 ...

20 UNDERTAKER

ADDRESS

FEB 5 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72931

CERTIFICATE OF DEATH.

38 D72931

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

2-FULL NAME Jacob Johnson

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	82	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maria Fentworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records. (Address)

15 Filed ..... 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

FEB 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 19 23

17

I HEREBY CERTIFY, That I attended deceased from February 17 19 23 to February 21 19 23.

that I last saw him alive on February 20 19 23.

and that death occurred, on the date stated above, at 2:35 A.M.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency
(Syphilitic)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Back

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical was etc

(Signed) Clyde Snell, M. D.

2-21 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

FEB 2 - 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

161589
D72932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72932

16-00

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eduard Sameuald

(a) RESIDENCE No 1712 Lemmon St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 22, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Charles Sameuald

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Lorenz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL.

15 Robert P. Harrison, Registrar

FEB 24 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1923, to Feb 16, 1923, that I last saw him alive on February 16, 1923, and that death occurred, on the date stated above, at 7.25 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery, bacillary, (Flexner)

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 13 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Stool Cultures

(Signed) A. H. Weech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

FEB 23 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

165380
D72933
11

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D72933

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. " " " ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Pinkett, Jr.

(a) RESIDENCE NO. 715 Ashland Ave ST., City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~: Charles Pinkett (father)

6 DATE OF BIRTH (month, day, and year): Jan. 7, 1923

7 AGE: Years — Months 1 — Days 11 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Maryland

PARENTS

10 NAME OF FATHER: Charles Pinkett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Alice Shelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address) JOHNS HOPKINS HOSPITAL Official

Robert P. Elliott, Registrar

. 19

Burial Permit Clerk.

FEB 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1923, to Feb. 16, 1923, that I last saw him alive on Feb. 16, 1923, and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Primary Pneumonia (bronchial)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Pneumococcus Meningitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) H. H. Mgee M.D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

FEB 23 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72934

CERTIFICATE OF DEATH.

21 D72934

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 Wellington ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Scott

(Residence in Baltimore: No. 832 Wellington Av. St.; 10 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) 10th (Day), 1863 (Year)

7-AGE, 59 yrs. 9 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto Co. Md

PARENTS.

10-NAME OF FATHER, John Scott

11-BIRTHPLACE OF FATHER (State or Country), Balto Co Md

12-MAIDEN NAME OF MOTHER Ukd Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Balto Co. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Scott

(Address) 832 Wellington Av

15-

Filed....., 191.... Robert F. Harrison
Registrar.

2-4-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feby (Month) 23 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1922, to Feb 23 1923, that I saw him alive on Feb 23 1923, and that death occurred, on the date stated above, at 2:20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 2 mos. 22 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 1 mos. ds.

(Signed) J Blount M. D.

3/23, 1923 (Address) 565 W Saratoga St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Mary, Hampden DATE OF BURIAL, Feb 26, 1923

20-UNDERTAKER A S Marshall ADDRESS 353 Balto Md

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72935

D72935

99-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1302 Linden Ave ST., 11 WARD)

2-FULL NAME Julia Dukary Stabler

(a) RESIDENCE NO. 1302 Linden Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 50? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alban G Stabler

6 DATE OF BIRTH (month, day, and year) 1836 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	87?	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Hamilton Bernard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Amelia Hoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant John L Hoff (Address) 1205 Linden Ave

15 Filed 24 1923 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23rd 1923

17 I HEREBY CERTIFY, That I attended deceased from February 10th 1923 to Feb. 22nd, 1923.

that I last saw her alive on February 22nd 1923,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Debility due to Advanced age

(duration) --- yrs --- mos -- ds.

18 Where was disease contracted if not at place of death? At residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ---

(Signed) Thomas L. Sharon, M. D.

Feb24 1923 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Feb 26 1923

20 UNDERTAKER Henry H. Jenkins Sons

ADDRESS McCulloh or Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72936

CERTIFICATE OF DEATH.

D72936

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 1514 Division ST., 14 WARD)

2-FULL NAME Archibald Alexander Burris

(a) RESIDENCE NO. McConnellsville, S.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Margaret L. Burris

6 DATE OF BIRTH (month, day, and year): Sept. 29 1856

7 AGE: 66 Years 4 Months 23 Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): McConnellsville, S.C.

PARENTS

10 NAME OF FATHER: Wm. Burris

11 BIRTHPLACE OF FATHER (city or town) (State or country): McConnellsville, S.C.

12 MAIDEN NAME OF MOTHER: Jane Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): McConnellsville, S.C.

14 Informant (Address): Margaret L. Burris (wife) McConnellsville, S.C.

15 Filed . 19 Robert T. Harrison, Registrar

B 24 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1923 to Feb. 23, 1923 that I last saw him alive on February 23, 1923 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the large & small intestine.

about (duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary): Intestinal obstruction

(duration) about mos. 5 ds.

18 Where was disease contracted if not at place of death? McConnellsville S.C.

Did an operation precede death? yes Date of Feb. 19, 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin D Jarrett M. D.

. 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Hill, S. C. DATE OF BURIAL: Feb. 24, 1923

20 UNDERTAKER: John O Mitchell, Jr. ADDRESS: 1 N. Fayette St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72937

D72937

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Gording Ave ST., Waverly WARD 27)

2-FULL NAME John B. Stebler

(a) RESIDENCE NO. 508 Gording Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Nellie Stebler

6 DATE OF BIRTH (month, day, and year) Dec. 10 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..min.
	36	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paperhanger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

052

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Frederick Stebler

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Frances Baum

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs. Nellie Stebler

(Address) 508 Gording Ave Waverly

15 Filed FEB 24 1923 19 Robert F. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 10, 1923, to Feby 22, 1923, that I last saw him alive on Feby 22, 1923, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis - pulmonary

Does not know

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Ex Lungs only

(Signed) Wm Delany Faroux, M. D.

1/24, 1923 (Address) 330 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Feby 27 1923
20 UNDERTAKER	ADDRESS
Henry Hoerle Son	1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72938

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72938

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1007 Somerset ST., 10 WARD)

2-FULL NAME John W. H. Haberkorn

(a) RESIDENCE NO. 1007 Somerset ST., 10 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 20 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER John A. Haberkorn

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Theresa Schreiber

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs. Theresa Haberkorn
(Address) 1007 Somerset

15 Filed 2 1923 ROBERT E. HARRISON, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1923, to Feb. 22, 1923, that I last saw h[illegible] alive on Feb 22 1923, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Nephritis (chronic)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Benj. D. Humphrey, M. D.

2/23, 1923 (Address) 1216 N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Feb. 26 1923

20 UNDERTAKER Henry Hoverkamp — ADDRESS 1301 E Eager St

24 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

72939 D72939

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 72939

11-002 D72939

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 545 W. Barre ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carolina Wilmer

(a) RESIDENCE No. 545 W. Barre ST., WARD North Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Joseph Wilmer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE ? Years 55 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer Mrs Lowry Mays

9 BIRTHPLACE (city or town) Oak City N C

(State or country)

PARENTS

10 NAME OF FATHER Lewis Harrell

11 BIRTHPLACE OF FATHER (city or town) Oak City N C

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Charley Harrell

(Address) 545 W Barre N

15 Filed FEB 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 22 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/20 1923, to 2/22 1923, that I last saw her alive on 2/20 1923, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. T. Howell M. D.

2/20 1923 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. mt auburn cemetery

DATE OF BURIAL Feb 27 1923

20 UNDERTAKER Edward Bryan

ADDRESS 631 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

72940 D72940

HEALTH DEPARTMENT—CITY OF BALTIMORE

72940 113 D72940

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 0.....

City of BALTIMORE: (No. 1619 Keyser St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian G. Chester

(Residence in Baltimore: No. 1619 Keyser St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	[illegible]

6-DATE OF BIRTH. August 25/22 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
yrs. 6 mos. 28 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto. MD.

PARENTS.

10-NAME OF FATHER. Chas. S. Chester

11-BIRTHPLACE OF FATHER. (State or Country). MD.

12-MAIDEN NAME OF MOTHER. Francis E. Frez

13-BIRTHPLACE OF MOTHER. (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis Chester

(Address) 1619 Keyser

15-FEB 25 1923 ROBERT R. KRAUTER,
Filed 192 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. ~~Feb~~ 23/23 192...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or Inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) hereon found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopnuemonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Malnutrition-gastro-intestinal indigestion since birth

(Duration) yrs. mos. ds.

(Signed) J. S. H. Dalles M. D.
(Coroner.)

2/23/23 (Address) 508 E. North

*State the Disease Causing Death, or, in deaths from Violent Causes, state (I) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cemetery.	Feb 26th 1923
20-UNDERTAKER.	ADDRESS
Geo. J. Roth.	1735 Harford Ave

Fully item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

72941 D72941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

72941 84 D72941

REGISTERED NO. .....

1-PLACE OF DEATH 1507 N Bethel St

CITY OF BALTIMORE: (No. 1507 N. Bethel ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Dorella Harryman

(a) RESIDENCE NO. 1507 N. Bethel ST., ... WARD 8

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 17 1922

7 AGE — Years: One — Months: One — Days: 6 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edward Harryman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Emma O'Donnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Emma Harryman

(Address): 1507 N Bethel st

FEB 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 1923, to Feb 23 1923,

that I last saw her alive on Feb 23 1923,

and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Infantile Tetany

(duration) ..... yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Infantile Tetany

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of ---

Was there an autopsy? no

What test confirmed diagnosis? Manifest symptoms

(Signed) C. H. Weatherred, M. D.

(Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Feb 24 1923

20 UNDERTAKER: Geo. J. Rusch

ADDRESS: 1735 Harford Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16-11-72942 Md

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72942

X 38

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 11 WARD)

2-FULL NAME William Burnell

(a) RESIDENCE NO. 603 Bradley St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 days mos. ds. How long in U. S., If of foreign birth? Virginia yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Bettie Burnell

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years (?) 43 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 Filed FEB 25 1923 ROBERT R. KRAUTER, Burial Permit Clerk. R. Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1923, to Feb 24, 1923, that I last saw him alive on Feb 24, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Bagg, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 2-27 1923

20 UNDERTAKER: David Taylor

ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—6-9-19—H. P. Co.—1000 Bks.

Bertha Ready. ✓

D72943

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D72943

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 827 Ostend St.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Ready

(a) RESIDENCE. NO. 827 Ostend ST., 21 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug 19- 1901

7 AGE Years 21 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Richard Ready

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Martha Sparks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Martha Ready

(Address) 827 Ostend St

15 Filed FEB 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/22 1923

that I last saw her alive on 2/21 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Aortic Insuff

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (over)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John G. Schwendeman M.D.

, 19 (Address) 11 W. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 2-26 1923

20 UNDERTAKER David Taylor

ADDRESS 910 Penna Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lucid

Spec.—1-10-21—M&T—1500 Bks.

Sienkewicz ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72944

CERTIFICATE OF DEATH.

90 D72944

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3401 Hudson ST., (WARD) 26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Sienkewicz

(a) RESIDENCE (No.) 3401 Hudson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) O&C

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Witalis Sienkiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Emanuel Raynysz

(Address) 3401 Hudson St

15 FEB 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1922 to Feb 23, 1923, that I last saw h— alive on Feb 23, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Rosner, M. D.

Feb 25, 1923 (Address) 80 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus — DATE OF BURIAL: Feb 26 1923

20 UNDERTAKER: John M. Weber — ADDRESS: 1803 Bank

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72945

CERTIFICATE OF DEATH.

106-001 D72945

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1567 Richland ST., 13 WARD)

2-FULL NAME Robert Allen Ohl

(a) RESIDENCE NO. 1567 Richland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 19th 1922

7 AGE — Years: — Months: 9 Days: 5 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md Maryland

PARENTS

10 NAME OF FATHER: George H. Ohl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Emma M. Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: George H. Ohl
(Address) 1567 Richland St. Balto. Md

15 Filed FEB 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14th, 1923, to Feb. 24th, 1923, that I last saw him alive on Feb. 24th, 1923, and that death occurred, on the date stated above, at 9.40 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) Elbert C. Reitzel, M. D.

Feb 24 1923 (Address) Cor. Pa. & Fulton Aves. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Feby 26 1923

20 UNDERTAKER: Harry W. Ellen — ADDRESS 1944 W. Norchan

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72946

CERTIFICATE OF DEATH.

100-001 D72946

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 807 N Castle ST. WARD) 7

2-FULL NAME Christina Degele

(a) RESIDENCE NO. 807 N. Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 11 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (~~HUSBAND~~ of (or) WIFE of John F. Degele

6 DATE OF BIRTH (month, day, and year) Mar 11 - 63

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	59	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Jacob Steeble

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John F. Degele 807 N. Castle

15 FEB 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 19 23 to Feb 22, 19 23 that I last saw h~~im~~ alive on Feb 22, 19 23 and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH* was as follows:

Organic Brain Disease following Bronchitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) with Cardiac Arterio Sclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Following Symptoms

(Signed) F. [illegible] M. D.

2-24, 19 (Address) 5000 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W.W. Carmel — DATE OF BURIAL 2/26 1923

20 UNDERTAKER Philip Herring — ADDRESS 2016 Eutaw

X-Be sure PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72947

D72947

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 208 N. Monument ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jay Gilbert

(a) RESIDENCE. NO. 208 N. Monument ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosalie G. Gilbert

6 DATE OF BIRTH (month, day, and year) [illegible] 12 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Drug Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Barnett Gilbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Mary J. Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Wm. E. Gilbert (Address) Relay Md.

15 Filed FEB 25 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. , 1922, to Feb. 23 , 1923

That I last saw h[illegible] alive on Feb. 23 , 1923

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Oedema Lungs
Due to Mitral Insufficiency
Do not know duration
Yrs. Mos. Ds.
Z the Heart Organ
Oedema 3 Days.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Death

(Signed) Standish McIlhenny M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Middleway W. Va.	Feb 26 1923

20 UNDERTAKER John O. Mitchell ADDRESS 1201 N. Fayette St.

Spec.—1-10-21—M&T—1500 Bks.

D72948

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D72948

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3822 Barrington Rd ST., 15 WARD)

2-FULL NAME Nancy E. Wallover

(a) RESIDENCE No. 3822 Barrington Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. J. Wallover

6 DATE OF BIRTH (month, day, and year) Sept 30, 1849

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
73	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10 NAME OF FATHER George W. Dungan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Anna E. Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio,

14 Informant Laura Klein

(Address) 3822 Barrington Rd.

15 FILED FEB 25 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1922, to Feb. 25, 1923.

that I last saw her alive on Feb. 24, 1923

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

Mitral (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Edw. F. Porter, M. D.

2-26-23 (Address) 340 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Beaver Pa. DATE OF BURIAL Feb. 27 1923

20 UNDERTAKER George J. Smith ADDRESS 1532 Hollins St.

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72949

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72949

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 W Lafayette ST.: 19 WARD)

2-FULL NAME Mary D Dickerson

(a) RESIDENCE. NO. 1629 W Lafayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: Charles A. Dickerson

6 DATE OF BIRTH (month, day, and year): 1851

7 AGE — Years: 71 — Months: — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dress maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Wash DC

PARENTS

10 NAME OF FATHER: Jefferson Davis

11 BIRTHPLACE OF FATHER (City or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mary E Newcomb 1740 Dolphin

15 Filed FEB 25 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 22, 1923, that I last saw h[er] alive on Feb 22, 1923, and that death occurred, on the date stated above, at 9 30 A. m.

The CAUSE OF DEATH was as follows: Carcinoma Sarcoma

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary): Diabetes

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic

(Signed) Signed C B Hendrix M. D.

Feb 24, 1923 (Address) 712 S. Bond Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — DATE OF BURIAL: Feb 25 1923

20 UNDERTAKER: Samuel N. Case — ADDRESS: 1406 Mosher

D72950

HEALTH DEPARTMENT--CITY OF BALTIMORE

D72950

CERTIFICATE OF DEATH

1-PLACE OF DEATH Provident Hosp. 15 Registered No. C

CITY OF BALTIMORE (No. 1614 Dunsum St. Ward) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Riley

(Residence in Baltimore: No. 1614 Dunsum St. St.; 15 yrs. mos. ds.)

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: Unknown (Month) (Day), 1868 (Year)

7-AGE: 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Private family

9-BIRTHPLACE (State or country): Va.

PARENTS

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (State or country): Not Known

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (State or country): Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. T. S. Hawkins

(Address) 1202 Druid Hill Ave.

15-Filed FEB 25 1923 ROBERT R. KRAUTER Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: 2 (Month) 21 (Day), 1923 (Year)

17-I HEREBY CERTIFY, That I attended deceased from Jan 30 1923 to Feb 21 1923 that I saw her alive on Feb 20 1923 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) yrs. 13 mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) T. S. Hawkins M. D.

Feb 26 1923 (Address) 1202 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Feb. 25, 1923

20-UNDERTAKER: Jno. M. Johnson

ADDRESS 1234 Etting St.

Spec.—1-10-21—M&T—1500 Blks.

D72951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72951

CERTIFICATE OF DEATH.

51

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 5 WARD)

2-FULL NAME Ruth Marks

(a) RESIDENCE NO. 216 Asquith ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 4 mos. — ds. How long in U. S., if of foreign birth? 9 yrs. 4 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	9	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Marks

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Fannie Danker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Joseph Marks (Address) 216 Asquith St

15 FEB 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 24 1923

17

I HEREBY CERTIFY, That I attended deceased from February 13, 1923, to February 24, 1923.

that I last saw h[illegible] alive on February 24, 1923.

and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pericarditis with Effusion

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Moses Gellman, M. D.

2/24 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Rising Sun — DATE OF BURIAL 2/25 1923

20 UNDERTAKER [illegible] & Simpson Bro — ADDRESS 1127 E Balto St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Acute Rheumatic Fever

Spec.—1-10-21—M&T—1500 Blks.

D72952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72952

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1336 W Saratoga ST., 15 WARD)

2-FULL NAME Charles H Queen

(a) RESIDENCE NO. 1336 W Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): August 6 1922

7 AGE — Years: — Months: 6 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED: Single

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Arthur Queen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va Orange Co

12 MAIDEN NAME OF MOTHER: Ella Villars

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va Orange Co

14 Informant: Mrs Etta Queen

(Address): 1336 W Saratoga St

15 Filed FEB 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1923, to Feb 24, 1923, that I last saw h[illegible] alive on Feb 23, 1923, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) 1 yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles E. Clark M. D.

Feb 24 1923 (Address) 1306 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Feb 26 1923

20 UNDERTAKER: Clarence Murphy — ADDRESS: 1364 Mc Cay

X. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of varlous pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec—12-23-21—E.B.R.S.—400 Bks.

D72953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D72953

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE: (No. 919 Fayn St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Ruchi

(a) Residence No. 919 Fayn St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Santie Ruchi

6-DATE OF BIRTH (month, day and year) Feb 14 1891

7-AGE. 32 yrs. mos. 10 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Italy

PARENTS:

10-NAME OF FATHER, Domnco Ruchi

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Mary Spadiri

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Santie Ruchi

(Address) 919 Fayn St

15- Filed FEB 25 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). February 24 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1923 to Feb. 24 1923

that I last saw him alive on Feb. 24 1923

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Urine, blood

(Signed) E. L. Crossnoe M. D

2. 25. 1923 (Address) Zue Hills

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Vincent	Feb 27 1923
20-UNDERTAKER.	ADDRESS
Wendell Oppelsdon	318 Bmn St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72954 V 181-001 D72954

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1603 E. Pratt ST. 3 WARD)
(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Clough
(Residence in Baltimore: No. 1603 E. Pratt St. 24 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 24th, 1865
(Month) (Day) (Year)

7-AGE. 57 yrs. 11 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Saw filer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country), Md

PARENTS.

10-NAME OF FATHER, James F. Clough

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Harriet Morgan

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James E. Clough

(Address) 2813 E. Monument St

15-
Filed FEB 25 1923 191... ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 22nd, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* Asphyxiation by Inhaling Illuminating Gas — accidental

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary).....
(Duration)..... yrs..... mos..... ds.

(Signed) Thos. B. Sutton M. D.
(Coroner)
Feb 23rd 1923 (Address) Curtis Bay Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore — DATE OF BURIAL, Feb 26, 1923

20-UNDERTAKER Fuhrman, Burke & Eager — ADDRESS 1734

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72955

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 737 Mc Henry ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mattie Stevens

(a) RESIDENCE NO. 737 Mc Henry ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? / yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Stevens

6 DATE OF BIRTH (month, day, and year): Unknown. 1884

7 AGE: 39 (Years / Months / Days / If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va Richmond

PARENTS

10 NAME OF FATHER: John Kemp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mr James D Stevens

(Address) 737 Mc Henry St

15 FEB 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/24/23 19

17 I HEREBY CERTIFY, That I attended deceased from 2/21/, 1923, to 2/24/23, 19, that I last saw h[illegible] alive on 2/23/23, 19, and that death occurred, on the date stated above, at 2 30 A. m.

The CAUSE OF DEATH* was as follows:

Pul Ptisis

(duration) [illegible] History 6 mo.? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel J Kemp, M. D.

2/24, 1923 (Address) 910 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: Feby 26 1923

20 UNDERTAKER: Peter F Howard & Son — ADDRESS: 901 Hollins St.

INFORMATION CONCERNING THIS PATERNAL RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D72956 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 5 181-001 D72956

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Lula Kelley

(Residence in Baltimore: No. 23 N. High St. St.; yrs. 29 mos. 4 ds. 2 1)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced (Write the word.) Married

6-DATE OF BIRTH. October 1st (Month) (Day) 1893 (Year)

7-AGE. 29 yrs. 4 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto md

PARENTS.

10-NAME OF FATHER. Henry Kelley

11-BIRTHPLACE OF FATHER, (State or Country). Balto md

12-MAIDEN NAME OF MOTHER. Elizabeth Burns

13-BIRTHPLACE OF MOTHER, (State or Country). Balto md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C Thompson

(Address) 1001 Bush St

15- Filed FEB 25 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 23rd (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:

1st Gas accident)

(Duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) 1 ds.

(Signed) C Bladel M. D.

(Coroner) (Address) 1436 Bway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Western Cemetery DATE OF BURIAL. Feby 26th 1923

20-UNDERTAKER. John F Cowan & Son ADDRESS 90 Hollins St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 D72957

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 So Furrow ST., 20 WARD)

2-FULL NAME Catherine O'Brien

(a) RESIDENCE NO. 201 So Furrow ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs Life mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 4- 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John O'Brien
(Address) 201 So Furrow

15 Filed FEB 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1923, to Feb 24, 1923

that I last saw her alive on Feb 24, 1923

and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred Kaelin M. D.

Feb 24 1923 (Address) 1735 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patrick's Cemetery	Feb 26 1923
20 UNDERTAKER MR. & MRS. N. S. FINK, FUNERAL DIRECTORS	ADDRESS 1732 W. PRATT STREET.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72958

CERTIFICATE OF DEATH.

74-001 D72958

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 841 Ducatel ST., 13 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Adelina Daniel

(a) RESIDENCE NO. 841 Ducatel ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Dec 23, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Michael Daniel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frometta Daniel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Moses Daniel

(Address) Marlboro Md

15 Filed FEB 25 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Feb 24, 1923, that I last saw her alive on Feb 23, 1923, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lentz, M. D.

2-24, 1923 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bait Hebrew

DATE OF BURIAL Feb 26 1923

20 UNDERTAKER J. Ahrens & Co

ADDRESS 1611 Madison Ave

Spec.—1-10-21—M&T—1500 Bks.

D72959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72959

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH Tioga & Norwood Ave

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ferdinand Jos Dralham

(a) RESIDENCE NO. Tioga & Norwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Edda M. Dralham

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

017

9 BIRTHPLACE (city or town) (State or country) Alexandria Va.

PARENTS

10 NAME OF FATHER Simon Dralham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Lizzie Schwartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs Edda Dralham

(Address) Tioga & Norwood Ave

15 FEB 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1922 to 2/24, 1923.

that I last saw him alive on 2/23, 1923.

and that death occurred on the date stated above, at 12 M P.m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical findings

(Signed) Fron Freedom M.D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew	Feb 26 1923
20 UNDERTAKER	ADDRESS
Jahrens & Co	Walnut

INFORMATION FURNISHED HEREIN—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72960

CERTIFICATE OF DEATH.

90 D72960

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1228 E Balt.

CITY OF BALTIMORE: (No. 1228 E Balto ST., 5 WARD)

2-FULL NAME Fagie Karsh

(a) RESIDENCE NO. 1225 E Balto Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 1 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abraham Karsh 1857

6 DATE OF BIRTH (month, day, and year): 1851

7 AGE: Years 72 | Months — | Days → | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Mot Weinstein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rachael

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: J. Fagus (Address) 1439 E. Balto St.

15 Filed FEB 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 25 1922, to Feb 21, 1923.

that I last saw him alive on Feb 21 1923,

and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): acute dilatation of the heart

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel Silverstein, M. D.

, 19 (Address) 22 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Int. Carmel | DATE OF BURIAL: Feb 25 23

20 UNDERTAKER: Jack Lewis | ADDRESS: 1439 E. Balto

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72961

CERTIFICATE OF DEATH.

21-002 D72961

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 108 East St. 5 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Eliza J. Johnson

(Residence in Baltimore: No. 108 East St. St.; yrs. 50 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. C

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Not known. 1.....
(Month) (Day) (Year)

7-AGE. 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. —
(b) General nature of industry, business, or establishment in which employed (or employer). —

9-BIRTHPLACE, (State or Country) Not known

PARENTS:

10-NAME OF FATHER. —

11-BIRTHPLACE OF FATHER, (State or Country). —

12-MAIDEN NAME OF MOTHER. —

13-BIRTHPLACE OF MOTHER, (State or Country). —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Tibbs

(Address) 108 East St

15- Filed FEB 25 1923 192.....

ROBERT R. KNAUER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb 20 23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) on the person and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) yrs. ..... mos. ..... ds.

(Signed) H. B. Clark M. D.
(Coroner)

(Address) 1133 E. Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence. .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Laurel Cemetery	Feb 25 1923
20-UNDERTAKER,	ADDRESS
Mrs. R. C. Elliott	1211 Islandale

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72962

CERTIFICATE OF DEATH.

100-00 D72962

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 N. Caroline ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Lauretta Thompson

(Residence in Baltimore: No. 717 N. Caroline St.; 6 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
F	C	~

6-DATE OF BIRTH, ... June (Month) 30 (Day), 1922 (Year)

7-AGE, ... yrs. 7 mos. 26 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Joseph Thompson

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Annie Williams

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Thompson mother

(Address) 717 N Caroline St

15-

Filed FEB 25 1923, 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Feb (Month) 20 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 13 1923, to Feb 20 1923, that I saw her alive on Feb 24 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

..... Bronchio-Pneumonia .....

..... (Duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. S. Young M. D.

2/25, 1923. (Address) 1429 E Mt Vernon Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	Feb 27, 1923
20-UNDERTAKER	**ADDRESS**
Mrs. R. E. Elliott	717 Caroline

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

D72963

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72963

CERTIFICATE OF DEATH.

100-001

5

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Forrest

(Residence in Baltimore: No. 304 S. Spring St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	black	single

6-DATE OF BIRTH. July (Month) 15/21 (Day) 1..... (Year)

7-AGE. 1 yrs. 7 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Isaih Forrest

11-BIRTHPLACE OF FATHER. (State or Country). unknown

12-MAIDEN NAME OF MOTHER. Lula Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lula Forrest

(Address) 304 S. Spring St.

15- Filed FEB 25 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb. 22/23 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopnuemonia

(Duration) ....yrs. ....mos. 6 ....ds.

CONTRIBUTORY (Secondary) Rickets

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. A. Power M. D. (Coroner.)

2/22/23 (Address) 508 E. North AVE.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery — DATE OF BURIAL. Feb 25 1923

20-UNDERTAKER. Mrs Rotea A Elliott — ADDRESS 1725 Ashland Ave

Spec. 1-10-21 M&T 1500 Blks.

D72964

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D72964

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1158 Cleveland ST. 21 WARD)

2-FULL NAME Minnie J. Zimmerman

(a) RESIDENCE No. 1158 Cleveland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William C. Zimmerman

6 DATE OF BIRTH (month, day, and year): June 2 1880

7 AGE: Years 42 | Months 10 | Days 15. | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Fairmount, Somerset Co. Md.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Reed.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: William C. Zimmerman (Address) 1158 Cleveland St.

15 Filed FEB 25 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 23. 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1921, to Feb 23, 1923 that I last saw her alive on Feb 23, 1923 and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John C. Zimmerman M. D.

Feb 24, 1923 (Address) 1126 W. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Feb 26, 1923

20 UNDERTAKER: Wm. & Jno. H. Teufel & Son — ADDRESS: 811 W. Fayette St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72965 99-001 D72965

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat (St.) 25th (Ward)

2-FULL NAME Rose O'Farrell

(a) RESIDENCE. No. Mt Hope Retreat St. 25 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11-1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germantown
(State or country) Pa

PARENTS

10 NAME OF FATHER Hugh O'Farrell

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Creile

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) Ireland

14 Informant Rose O'Farrell Mt Hope Retreat
(Address) Mt Hope Retreat

15 Filed FEB 25 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 17th 1919 to Feb 24 1923, that I last saw h[er] alive on Feb 24 1923, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) 3 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Dementia Senile

(duration) 3 yrs. 0 mos. 6 ds.

18 Where was disease contracted if not at place of death? Germantown Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Germantown, Pa	2/26 1923
20 UNDERTAKER Henry W. Meas & Son	ADDRESS 805 N. Calvert St

via Penn. R.R. - Escort Miss Eliza. Lewis

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72966

CERTIFICATE OF DEATH.

11-001 D72966

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 660 Cokesbury ST., 9 WARD)

2-FULL NAME Ethel R. Schamel

(a) RESIDENCE NO. 660 Cokesbury ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas G. H. E. J.

6 DATE OF BIRTH (month, day, and year): Jan - 20 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	2	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Henry M. Schamel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Eva G. Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co. Md

14 Informant (Address): Henry M. Schamel 660 Cokesbury Ave

15 Filed FEB 25 1923 ROBERT R. ARNOLD, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-23- 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1923, to Feb 23, 1923, that I last saw h-e alive on Feb 23, 1923, and that death occurred, on the date stated above, at 1130 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) John D. Fauby, M. D.

2/24 1923 (Address) 3522 Greenmount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: London Park Cemetery

DATE OF BURIAL: 2/26 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Russell 3902 Groveland Ave
Dr. Kelly 2/24/23

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72967

CERTIFICATE OF DEATH.

10 D72967

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5320 Fremont Ave ST., 27 WARD)

2-FULL NAME Nimietta Wigginton

(a) RESIDENCE NO. 5320 Fremont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 11-1921

7 AGE: Years 1 Months 8 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Howard Wigginton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Nimie Candis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Howard Wigginton

(Address): 5320 Fremont Ave

15 FEB 25 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 26 1923

17

I HEREBY CERTIFY, That I attended deceased from 2/23, 1923, to 2/24, 1923,

that I last saw her alive on 2/24, 1923,

and that death occurred, on the date stated above, at 1.00 A. m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Laryngeal)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Henry Russell, M. D.

, 19 (Address) 3902 Groveland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem DATE OF BURIAL: Feb 26 1923

20 UNDERTAKER: Lowe Cook ADDRESS: 502 E South

207

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72968

CERTIFICATE OF DEATH.

65-002

D72968

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 172 Longwood ST., 15 WARD)

2-FULL NAME Robert Wesley Sun

(a) RESIDENCE NO. 172 Longwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Sun

6 DATE OF BIRTH (month, day, and year) Dec 22 57

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Mason

(b) General nature of industry, business, or establishment in which employed (or employer) McClure Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Geo Sun

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Emma Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Robt Sun

(Address) 172 Longwood

15 FEB 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 192[illegible], to Feb 22nd, 1923.

that I last saw him alive on Feb 22nd, 1923

and that death occurred, on the date stated above, at 7.30 Pm.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease.

(duration) abt 4 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hopkins Hospital Examined Lymph nodes microscopically

(Signed) H. Degen, M. D.

, 19 (Address) 120 Poplar Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

Loudon Park Cem Feb. 28 1923

20 UNDERTAKER ADDRESS

Wm Cook 650 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D72969

101-001 D72969

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 172 Mc Cubbin ST.: 6 WARD)

2-FULL NAME Daniel Wilmore

(a) RESIDENCE. No. 1727 Mc Cubbin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma Wilmore

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 61 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Emma Wilmore
(Address): 1727 Mc Cubbin

15 Filed FEB 25 1923 ROBERT R. KEMP, M. D. Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1923, to Feb 24, 1923,
that I last saw h.. alive on Feb 23, 1923,
and that death occurred, on the date stated above, at 3.45 p. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No

(Signed) W. E. Burns, M. D.
, 19 (Address) 2417 Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Feb 26 19
20 UNDERTAKER	ADDRESS
Milton Davis	315 N Eden

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Tuberculosis

D72970 D72970 D72970

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 N. Wolfe ST., 6 WARD)

2-FULL NAME Mary J. Giney

(a) RESIDENCE No 215 N. Wolfe ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Giney

6 DATE OF BIRTH (month, day, and year) Jan 9-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	70	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Wm. Whalen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire

12 MAIDEN NAME OF MOTHER Gantbrun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. P. Maloney
(Address) 215 N. Wolfe St.

15 Filed FEB 26 1923 ROBERT B. KNAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 22, 1922, to Feb 23, 1923, that I last saw he alive on Feb 22, 1923, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

CONTRIBUTORY (Secondary) Chronic Bronchitis (duration) yrs. mos. ds.

Sclerosis of Coronary Arteries (duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. H. Meyer Jr. M. D.

2/25 1923 (Address) 2638 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 2/26 1923

20 UNDERTAKER J. J. Moran — ADDRESS 2200 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D72971

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72971

129 D72971

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 Kennedon ST., 6 WARD)

2-FULL NAME Michael J. Ward

(a) RESIDENCE NO. 22 Kennard ave ST., 6 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Ward

6 DATE OF BIRTH (month, day, and year): Nov. 1854

7 AGE — Years: 68 — Months: 2 — Days: — If LESS than 1 day, hrs. or .....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Timothy Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Can't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): E. Ward 22 E. Kennard ave.

15 Filed FEB 26 1923 ROBERT R. KNAUER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1923, to Feb. 24, 1923, that I last saw him alive on Feb 23, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Gustav T. Wolbrecht, M. D.

Feb. 25 1923 (Address) 11 20 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: Feb 26 1923

20 UNDERTAKER: J. A. Moran — ADDRESS 300 E Preston

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72972 100-001 D72972

CERTIFICATE OF DEATH

1-PLACE OF DEATH Boy Rus Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 20 WARD)

2-FULL NAME Sarah Hyser

(a) RESIDENCE No. 2734 Talbert ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Edward Hyser

6 DATE OF BIRTH (month, day, and year) March 11, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73.	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna. Nativity

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant (Address) Boy Rus Hospital Balt, Md.

15 Filed FEB 26 1923 19 Burial Permit Issued by Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 25 1922 to Feb. 24 1923

that I last saw h alive on Feb. 22 1923

and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis Brain

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Private

Did an operation precede death? No Date of

Was there an autopsy? No Clinical Data

What test confirmed diagnosis?

(Signed) N. S. Boorum M. D.

19 (Address) Boy Rus Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL Feb 26 1923

20 UNDERTAKER J. E. Ernst Sons ADDRESS 1715 N Charles St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D72973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D72973

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hosp St. or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lola A Kelley

(Residence in Baltimore: No. 1326 Mehenry St.; yrs. 14 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, December (Month) I, (Day) 1921 (Year)

7-AGE, I yrs. 2 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William H. Kelly

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mable A. Flaherty

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Kelly

(Address) 1326 Mehenry St.

15- Filed FEB 26 1923, 191... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 23 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 17 1923 to Feb 23 1923 that I saw h[illegible] alive on Feb 23 1923, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs...mos...ds.

(Signed) F. B. Wilkinson M. D.

Feb 24, 1923 (Address) Md. Gen. Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery | DATE OF BURIAL, Feb. 26, 1923

20-UNDERTAKER Harry H. Witzke | ADDRESS 1531 W. Lombard.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72974 D72974

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 349 S. Fulton Ave. St.: 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Geiger

(a) RESIDENCE. No. 349 S. Fulton Ave. St., Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred about 25 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ the late Theresa Geiger

6 DATE OF BIRTH (month, day, and year) October 13, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Clements Geiger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: George L. Kaiser
(Address): 349 S. Fulton Ave.

15 Date: FEB 26 1923

ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 19, 1923, to Feby 22, 1923, that I last saw h[illegible] alive on Feby 22, 1923, and that death occurred, on the date stated above, at 10P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) ✓

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? -

What test confirmed diagnosis? -

(Signed) M. Donnelly M. D.

2/23, 1923 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Feb. 26, 1923

20 UNDERTAKER: Harry W. Witzke ADDRESS: 1531 W. Lombard

N. B.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72975

CERTIFICATE OF DEATH

74-201 D72975

1-PLACE OF DEATH Monument & Bel Air Road & Park

REGISTERED NO.

CITY OF BALTIMORE: (No. Hotel Sherwood ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARY ELINOR FREDERICK

(a) RESIDENCE NO. Hotel Sherwood ST., 11 WARD (Resident)
(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? 84 yrs. 11 mos. 14 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Aloysisius Frederick

6 DATE OF BIRTH (month, day, and year) Mar-10-1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Everist

11 BIRTHPLACE OF FATHER (city or town) Harford Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Carr

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss KatharineB. Frederick
(Address) Hotel Sherwood, City

15 Filed FEB 26 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1923, to Feb. 24, 1923.

that I last saw her alive on Feb. 23, 1923.

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 26 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Hypertension Endocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Stewart & Mowen, M. D.

19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL NEW CATHEDRAL CEMETERY

DATE OF BURIAL FEB-26-23

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY in years, months and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Consulted

D72976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002 D72976

1-PLACE OF DEATH St. Vincents Infant Asylum

CITY OF BALTIMORE: (No.) 1401 Division ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Newman

(a) RESIDENCE NO. 1461 Division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/15/22

7 AGE — Years: — Months: 6 Days: 9 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: John J. Fahey Jr

(Address) 13[illegible] Light St

15 FEB 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1923, to Feb 24, 1923.

that I last saw him alive on Feb 24, 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(over)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) not known —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough, M. D.

, 19 (Address) 2735 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mary Carey Co.

DATE OF BURIAL: 2/26/1923

20 UNDERTAKER: J. J. Fahey Sons

ADDRESS: 1318 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D72977

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72977

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 S. Rose ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Grason

(a) RESIDENCE. NO. 607 S. Rose ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 15 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Grason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Kate Grason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Kate Grason

(Address) 607 S. Rose St.

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 7th, 1923, to Feby 25th, 1923, that I last saw h[illegible] alive on Feby 19th, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Valvular Disease Heart

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leslie W Athey, M. D.

Feby 25 1923 (Address) 1003 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Feb. 27 1923
20 UNDERTAKER Pott & Sumwalt Inc.	ADDRESS 1441

NOTICE—THIS CERTIFICATE, WHEN ADDRESSED, IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Barcu 2105 N. Charles

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72978

CERTIFICATE OF DEATH.

74-001

D72978

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2129 Huntingdon St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Martin

(a) Residence No. 2129 Huntingdon St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 3 1861

7-AGE, 61 yrs. 5 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, Robert Martin

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto Co

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Harford Co

14-

(Informant) Wm C. Fergusson

(Address) 2129 Huntingdon Ave

15-

Filed FEB 26 1923 By ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-25-23

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1923 to Feb 25 1923

that I last saw her alive on Feb 24 1923

and that death occurred, on the date stated above, at 12.50 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 55 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) E. H. Pekus, M. D.

Feb 25 1923 (Address) 2105 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Pettit Cemetery Harford — DATE OF BURIAL, 4/27 1923

20-UNDERTAKER, Wm Cook — ADDRESS 502 E North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72979

CERTIFICATE OF DEATH.

3 / D72979

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2731 Pratt ST., 20 WARD)

2-FULL NAME Henry D. Bach

(a) RESIDENCE No. 2228 Christian ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Bach

6 DATE OF BIRTH (month, day, and year): Feby 9 1888

7 AGE: Years 35 Months 10 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Attorney

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Balt Md

PARENTS

10 NAME OF FATHER: Michael J Bach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary L Snader

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Lena Bach 2228 Christian St

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1921, to July 24, 1923, that I last saw h[illegible]ive on July 24, 1923 and that death occurred, on the date stated above, at 8:50 m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Oedema Lungs

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death? Place Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam

(Signed) John A. Graham, M. D.

July 25 1923 (Address) 1219 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 7/28 1923

20 UNDERTAKER: Williamson & Nattan — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Graham 1219 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

D72980

HEALTH DEPARTMENT—CITY OF BALTIMORE

Gardner
Pauline Eager

CERTIFICATE OF DEATH.

58-001

D72980

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3710 E. Pratt St., No. Ward)

2-FULL NAME Minnie Walden

(a) RESIDENCE No. 3710 - E - Pratt St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: John Walden

6 DATE OF BIRTH (month, day, and year): Sept 10-1867

7 AGE — Years: 60 — Months: 5 — Days: 14 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Strauby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: John Walden (Address): 3713 E Pratt

15 FEB 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 24 19 23

17 I HEREBY CERTIFY, That I attended deceased from ..., 19 ..., to ..., 19 ..., that I last saw h... alive on ..., 19 ..., and that death occurred, on the date stated above, at 7 1/2 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Chronic

(duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) Cirrhosis

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..., M. D.

..., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: 2/28 19 23

20 UNDERTAKER: W M Cook — ADDRESS: 502 N Mo

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72981

CERTIFICATE OF DEATH.

3 | D72981

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2401 Kush Boulevard ST. 25 WARD)

2-FULL NAME Charles H. Smith

(a) RESIDENCE NO. 1122 Sexton ST. Thomas Park WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced: (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15 1902

7 AGE: Years 20 Months 7 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Meter Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Gas Co - 86

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wilson Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Mary E Insley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant: Mrs Annie E Gibson (Address) 1122 Sexton

15 Filed [illegible] 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 19 23

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1923, to Feb. 23, 1923, that I last saw him alive on Feb. 23, 1923, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Symptoms

(Signed) Wm S Schmunnel, M. D.

, 19 (Address) 3101 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pt. Point DATE OF BURIAL: Feb 27 19 23

20 UNDERTAKER: Wilson and Scott ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72982

CERTIFICATE OF DEATH.

100-00 D72982

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hosp. (WARD) 2

2-FULL NAME Wilhelm Sobieski

(a) RESIDENCE NO. 621 S. Dallas ST. Dallas WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Elizabeth Sobieski

6 DATE OF BIRTH (month, day, and year) May 21-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	71	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth C Sobieski

(Address) 621 S. Dallas

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1923 to Feb 25, 1923, that I last saw him alive on Feb 24, 1923, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene right foot and leg (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2/24/23

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lloyd W. Reese M. D.

2/25 1923 Address Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cemetery

DATE OF BURIAL 2/28 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D72983

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cedar & Locust Aves. St. 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah F. Davis.

(Residence in Baltimore: No. Cor. Cedar & Locust Aves St.; Overlea yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May 30 1846
Feb 25, 1923
(Month) (Day) (Year)

7-AGE, 76 yrs. 8 mos. 25 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Gartside

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Emaline Ford

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. F. Fuhrman

(Address) Cedar & Locust Aves

15-

Filed FEB 28 1923, 191.... ROBERT R. KRAUTER Clerk
Burial Permit
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb 25th, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 12th 1922, to Feb 25th 1923, that I saw h[illegible] alive on Feb 24 1923, and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines & stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Sarah A. Pratt M. D.

2/25/23, 191... (Address) Overlea

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore — DATE OF BURIAL, Feb. 27..., 1923

20-UNDERTAKER Lemmon — ADDRESS 502 E. Madison

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72984 — 90 — D72984

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 E. Winston Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth N. Rasch

(Residence in Baltimore: No. 818 E. Winston Ave St.; 62 yrs., 8 mos. 26 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May (Month) 28 (Day), 1860 (Year)

7-AGE, 62 yrs. 8 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Koch

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Alvina Rietscher

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry Rasch

(Address) 818 E. Winston Ave

15-

Filed FEB 26 1923 191.....

ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February (Month) 24 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 24 1922, to Feb 24 1922, that I saw her alive on Feb 24 1922, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Mitral & Aortic Insufficiency

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(Duration) yrs. mos. 3 ds.

(Signed) D. W. Brofy M. D.

Feb 25, 1923 (Address) 501 Sheridan Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem — DATE OF BURIAL, Feb 26, 1923

20-UNDERTAKER Chas. E. Franck — ADDRESS 802 Madison

Spec.—1-10-21—M&T—1500 Bks.

D72985

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-001
D72985

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1444 W 36 St., 13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjiam F Mathias

(a) RESIDENCE NO. 1444 W 36 St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 4 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George B Mathias (Address) 1444 W 36 St

15 Burial Permit Issued FEB 26 1923 ROBERT R. RYAN (L.S.) Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 1923 to Feb 25 1923 that I last saw him alive on 2/25 1923 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cirrhosis liver

(duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred W Dr 2 Ho M.D.

2/25 1923 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, REMOVAL OR CREMATION Greenmount Pleasant Valley DATE OF BURIAL Feb 27 1923

20 UNDERTAKER Chenoweth & Son ADDRESS Chestnut

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer. Farm laborer. Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook. Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma. Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Alcoholic

D72986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D72986

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 707 Bunnecke St. 13 WARD)

2 FULL NAME Mrs. Rose Harvey

(Residence in Baltimore: No. 707 Bunnecke)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(67 yrs., 7 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX. Female

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word) Widowed

6 DATE OF BIRTH July (Month) 6 (Day), 1855 (Year)

7 AGE, 67 yrs. 7 mos. 18 ds.

If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work. House Work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

9 BIRTHPLACE (State or Country) MD

PARENTS.

10 NAME OF FATHER Robert Cougle

11 BIRTHPLACE OF FATHER (State or Country) MD

12 MAIDEN NAME OF MOTHER Sarah McBride

13 BIRTHPLACE OF MOTHER (State or Country) MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer Harvey

(Address) 707 Bunnecke ave

15

Filed ..... 191 .....

ROBERT R. KRAMER, Burial Permit Clerk

Burial Permit Registrar.

FEB 26 1923

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH Feb 23 (Month) (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Valvular disease of heart

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) John H. Emmert M. D. (Coroner)

Feb 27, 1923 (Address) 2232 Rld Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, OR REMOVAL St Marys Hampden DATE OF BURIAL Feb 26, 1923

20 UNDERTAKER Chenoweth & Son ADDRESS Chestnut ave

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D72987

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72987

CERTIFICATE OF DEATH.

159-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Jackson ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Prescott Reilly

(a) RESIDENCE NO. 1620 Jackson ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 9-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Allen P. Reilly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Ackurry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Allen P. Reilly (Address) 1620 Jackson St

15 FEB 26 1923 Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1923, to Feb 24, 1923, that I last saw him alive on Feb 24, 1923 and that death occurred, on the date stated above, at 11.05 P m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) yrs. 3 mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) Sidney H. Streett, M. D.

2/26/1923 (Address) 405 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Feb 26 23

20 UNDERTAKER Wm Tickner & Sons

ADDRESS North Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-1921 M&T 1500 Blks.

D72988

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 ✓ D72988

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 E. Baltimore ST., 15 WARD)

2-FULL NAME Caroline Henrietta Meyer

(a) RESIDENCE NO. 1918 W. Northern ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Oct 23 1848

7 AGE: Years 74 Months 4 Days 1 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: John D. Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Bertha Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Mrs. Forsyc-Rauch

(Address) 262 Wilbrecham Ave

15 Filed FEB 26 1923 [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29 —, 1923, to Feb. 23, 1923,

that I last saw [illegible] alive on [illegible], 1923,

and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis — Diabetes — Bright's (albuminuria + casts)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Operation for removal of eye (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Feb 23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herbert Laclyn — M. D.

, 19 (Address) 516 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Baltimore Cem

DATE OF BURIAL: 2/27/23

20 UNDERTAKER: Wm Fiedler & Son

ADDRESS: Nor 2d

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D72989

(PLACE OF DEATH)

90 D72989

REGISTERED No. C

CITY OF BALTIMORE (No. 3023 N. North Ave 15 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1. FULL NAME Theodore Rivardi Smith

(Residence in Baltimore: No. 3023 N. North Ave. St.; 58 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word): Widower

6 DATE OF BIRTH: Sept. (Month) 8 (Day), 1861 (Year)

7 AGE: 61 yrs. 5 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work: Coal Broker, (b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Henry Smith

11 BIRTHPLACE OF FATHER (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Amanda Rivardi

13 BIRTHPLACE OF MOTHER (State or country): Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Mary Smith

(Address) 3023 N. North Ave.

15 Feb 26 1923, 191 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. (Month) 22 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13th, 1923, to Feb 22nd 1923, that I saw him alive on Feb. 21st, 1923, and that death occurred, on the date stated above, at 10.30 A. m. The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart. Acute and Mitral Regurgitation

(Duration) yrs. mos. 10 ds

Contributory (SECONDARY) Cardiac Sclerosis

(Duration) yrs. mos. ds.

(Signed), Herbert E. Good M. D.

Feb 24th, 1923. (Address) 3048 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: Feb. 26, 1923

20 UNDERTAKER: C. E. Hughes

ADDRESS: 4214 W. Broadway

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72990 11-001 D72990

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1131 S. Sharp ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Jane Farley

(a) RESIDENCE NO. 1131 S. Sharp ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept, 16, 1922

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or min.
—	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Louis Farley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Peters burg Virginia

12 MAIDEN NAME OF MOTHER Catherine Sinclair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Maryland

14 Informant Louis Farley

(Address) 1131 S. Sharp St.

15 Filed FEB 26 1923 ROBERT F. [illegible] Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb, 23 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb, 19, 1923, to Feb, 23, 1923, that I last saw h[illegible] alive on Feb, 22, 1923, and that death occurred, on the date stated above, at 3 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Francklin M. D.

2/26, 1923 (Address) 122 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn C[illegible] DATE OF BURIAL: Feb 26 1923

20 UNDERTAKER: J. H. Brown's Son ADDRESS: 1080 Mark[illegible] st

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72991 D72991

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 21. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Peter Rice

(Residence in Baltimore: No. 1408 S Carey St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Widower

6-DATE OF BIRTH. Don't Know (Month) (Day) (Year)

7-AGE. 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Book Keeper
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Robt Rice

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Harry Blanquette

(Address) 1405 Carey St

15-

FEB 26 1923 ROBERT R. KRAUTER,
Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb (Month) 24 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) N. R. Formwalt M. D. (Coroner.)

2-26 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Peters Cem DATE OF BURIAL. Feb 27 1923

20-UNDERTAKER. John J Cowan Son ADDRESS 701 Hollins

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D72992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D72992

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3329 Paine St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Sherman.

(Residence in Baltimore: No. 3329 Paine St. St. 9 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED,~~ (*Write* the word.) Married

6-DATE OF BIRTH, March 15, 1880
(Month) (Day) (Year)

7-AGE, 42 yrs. 11 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Noah Sherman.

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Louisa Hetzell

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Sherman

(Address) 3329 Paine St

15-
Filed FEB 26 1923, 191.....
ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 24, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancerous Abdomen.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

2/25, 1923 (Address) 3622 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hampstead

DATE OF BURIAL, 2/27, 1923.

20-UNDERTAKER, [illegible] WALTER DAVIS, FUNERAL DIRECTOR, Graham Pearce

ADDRESS 3307 Paine St

Spec.—1-10-21—M&T—1500 Bks.

D72993

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D72993

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore, Md.

CITY OF BALTIMORE: (No. Provident Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Jones

(a) RESIDENCE NO. 1131 Penna. Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Feb. 23 1910

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
12	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schlgrl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga. Ted

PARENTS

10 NAME OF FATHER Mr Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ted

12 MAIDEN NAME OF MOTHER Mamie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ted

14 Informant Mamie Jones

(Address) 1131 Penna Ave.

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1923 to Feb. 23, 1923.

that I last saw her alive on Feb. 22, 1923.

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. S. White, M. D.

2/26 1923 (Address) 1118 Druid Hill Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 2/26 1923

20 UNDERTAKER Samuel Hemsley

ADDRESS Middle

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72994

D72994

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 956 Franklin Road ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Jackson

(a) RESIDENCE. No. 956 Franklin Road ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. DO NOT WRITE ON THIS SPACE RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): widowed.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: William Jackson.

6 DATE OF BIRTH (month, day, and year): August 17 1859

7 AGE — Years: 63 — Months: 6 — Days: 7 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Howard Co; Md.

PARENTS

10 NAME OF FATHER: ? Jackson.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co, Md.

12 MAIDEN NAME OF MOTHER: ? ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co, Md.

14 Informant: Cora Jackson

(Address): 958 Franklin Rd.

15 Filed FEB 26 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 19 1923, to Feb 25 1923, that I last saw her alive on Feb 23 1923, and that death occurred, on the date stated above, at 8:00 a. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): organic heart disease

(duration) 4 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? percussion & auscultation

(Signed) Chester Riland., M. D.

2-24 1923 (Address) 253 E Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem — DATE OF BURIAL: 2/27/23

20 UNDERTAKER: Edmund Hensley — ADDRESS: [illegible]

Spec.—1-10-21 M&T 1500 Bks.

D72995 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 100-001 D72995

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hosp 26 REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Wills

(a) RESIDENCE NO. Bay View Hosp ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or .....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant (Address) Roy Lewis

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24 1923

17 I HEREBY CERTIFY, That I attended deceased from 7/14/21, 19..., to 2/24, 19 23 that I last saw h...alive on 2/24, 19 23 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bath

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Clyde Mitchell, M. D.

2/25 19 (Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL 2/27 1923

20 UNDERTAKER Samuel Devereux ADDRESS 5708 Reisterstown Rd

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72996

CERTIFICATE OF DEATH.

100-09 D72996

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 W. West ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Baker

(a) RESIDENCE NO. 505 W. West st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) md.

PARENTS

10 NAME OF FATHER Frank Baker

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Snyder

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Frank Baker (Father)

(Address) 505 W. West st

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1923 to Feb 23, 1923,

that I last saw h[illegible]live on Feb 23, 1923,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Primary)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. R. Campbell M. D.

Feb 26, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL Feb. 26 1923

20 UNDERTAKER James Dignan & Son ADDRESS 1000 S Paca st

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Bufano ✓

D72997 — CERTIFICATE OF DEATH. — 31 — D72997

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH: Baltimore Md.

CITY OF BALTIMORE: (No. 4825 Delaware Ave ST.; 27 WARD)

2-FULL NAME: Arthur Bufano

(a) RESIDENCE. No. 4825 Delaware Ave. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances C. Bufano

6 DATE OF BIRTH (month, day, and year): Sept. 14 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance Collector

(b) General nature of Industry, business, or establishment in which employed (or employer): 071

(c) Name of employer: John Hancock Life Ins Co

9 BIRTHPLACE (city or town) (State or country): Philadelphia

PARENTS

10 NAME OF FATHER: Michael Bufano

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Concetta Petrocuno

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Mrs. Frances Bufano (Address) 4825 Delaware ave

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1923, to Feb. 24, 1923,

that I last saw him alive on Feb. 20 Feb. 24 1923,

and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia and Pulmonary Congestion

about
(duration) yrs. 1 mo. 10 ds.

CONTRIBUTORY (Secondary): Pulmonary Tuberculosis (duration) about 1 yr. 2 mos. ds. according to family statement

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. M. Johnson, M. D.

(Address) 3928 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb 27 1923
20 UNDERTAKER: James Dignan & Son	ADDRESS: 1000 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72998 ✓ D72998

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 Beason St.: 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minna Martin

(Residence in Baltimore: No. 1633 Beason St.: 55 yrs.. mos. ds.)

1. PHYSICIANS should state ... nent of OCCUPATION is very ... important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

3-DATE OF BIRTH, Feb. 7, 1849 (Month) (Day) (Year)

7-AGE, 73 yrs. 0 mos. 17 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Michael Zaenkle

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Annie

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Weissmann

(Address) 1633 Beason St

15-

Filed FEB 26 1923, 191... ROBERT R. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 24th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 16th, 1923, to Feb. 24th, 1923, that I saw h[illegible] alive on Feb. 23rd, 1923, and that death occurred, on the date stated above, at 12 [illegible] a.m.

The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ... yrs. ... mos. 6 ds.

(Signed) Harry Weibel M. D.

2/26, 1923 (Address) 1224 Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cem

DATE OF BURIAL, Feb. 26, 1923

20-UNDERTAKER F. A. Krauter & Son

ADDRESS 703 Hanover St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D72999

CERTIFICATE OF DEATH.

100-001

D72999

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolf Gaidys

(a) RESIDENCE NO. 115 S Paca ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Nefrite

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND (or) ~~WIFE~~ of: Pauline Gaidys

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE: Years 35 | Months | Days | If LESS than 1 day, hrs. or mtn.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER: Adolph Gaidys

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lithuania

14 Informant: Paulina Gaidis

(Address) 115 S Paca street

15 FEB 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-25 1923

17

I HEREBY CERTIFY, That I attended deceased from 2-23, 1923, to 2-25, 1923,

that I last saw h[illegible] alive on 2-25, 1923,

and that death occurred, on the date stated above, at 3.25 A m.

The CAUSE OF DEATH* was as follows:

Diffuse Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Milton C Lang, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Feb 28. 1923

20 UNDERTAKER: John Grebliunas — ADDRESS: 415 S. Paca St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73000

D73000

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp Ass'n ST., 3 WARD)

2-FULL NAME Mrs. Anna Rosen

(a) RESIDENCE NO. 30 N. Exeter St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 mos. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kirkman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	53.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1439 E. Baltimore St.

15 FEB 26 1923 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25, 1923

17

I HEREBY CERTIFY, That I attended deceased from February 23, 1923, to February 25, 1923.

that I last saw her alive on February 25, 1923.

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Hemiplegia.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Gen. Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hosp

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Moses Gellman, M. D.

2/26, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cypresdale

DATE OF BURIAL Feb 27 1923

20 UNDERTAKER Jacob Lewis, 1439 E. Balto

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73001

CERTIFICATE OF DEATH.

90 D73001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1040 S. Sharp St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles G. Slemaker.

75 ---------

(Residence in Baltimore: No. 1040 S. Sharp St. St.; yrs....mos....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male.	White.	Married.

6-DATE OF BIRTH. January 15th. 1847. 1.....
(Month) (Day) (Year)

7-AGE. 76 yrs. 1 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Painter.
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Annapolis, Md.

PARENTS.

10-NAME OF FATHER, John H. Slemaker.

11-BIRTHPLACE OF FATHER, (State or Country). Annapolis, Md.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dessie E. Slemaker. (wife)

(Address) 1810 St. Paul St.

15-

FEB 26 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 23rd. 1923, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) Otto Feinhorn M. D.
(Coroner.)

Feb. 26 192 3. (Address) 1217 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL. July 27 19 23

20-UNDERTAKER. John A. Mitchell ADDRESS 1 West Lexington St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73002 D73002

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1940 Patterson Park Ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie J. Chelton

(a) RESIDENCE NO. 1940 Patterson Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of: George W. Chelton

6 DATE OF BIRTH (month, day, and year): March 7 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Severn Cullen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Magdalene McCullough (Address) 1707 E Biddle St

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): FEB 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 1920 to Feb 22 1923.

that I last saw her alive on Feb 21 1923,

and that death occurred, on the date stated above, at 4-23 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): General Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Signed: Albert L. Levy M. D.

(Address) 1235 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: 2-26 1923

20 UNDERTAKER: C & B Hale — ADDRESS: 1158 E Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D73003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D73003

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1431 Battery Ave ST., 24 WARD)

2-FULL NAME Theresa Miller

(a) RESIDENCE NO. 1431 Battery Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Conrad Miller

6 DATE OF BIRTH (month, day, and year): Sept 26 1877

7 AGE — Years: 45 — Months: 4 — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph Stolle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Theresa Schiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Conrad Miller

(Address) 1431 Battery ave

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Feb 24, 1923, that I last saw h— alive on Feb 24, 1923, and that death occurred, on the date stated above, at 4 12 A m.

The CAUSE OF DEATH* was as follows: Uraemia (Nephritis)

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross (A a Co)

DATE OF BURIAL: 2-27 1923

20 UNDERTAKER: E & B Hale

ADDRESS: 115 E West St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73004

CERTIFICATE OF DEATH.

74-001 D73004

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 S. Wilkens ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Baumgartner.

(a) RESIDENCE NO. 140 S. Wilkens ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Baumgartner.

6 DATE OF BIRTH (month, day, and year) Oct. 13th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Hans Baumgartner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Baumgartner (Address) 140 S. Wilkens St.

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1923, to Feb-23, 1923, that I last saw h[illegible] alive on Feb 20, 1923, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Apoplexy

(duration) yrs. mos ; ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms.

(Signed) Wm C. Gallop, M. D.

2.25. 1923 (Address) 57 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL Feb 26 1923

20 UNDERTAKER Lilly + Zeiler — ADDRESS 403 S. Wolfe St

Spec.—I-10-21—M&T—1500 Bks.

D73005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D73005

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 S. Ellwood Ave ST., 1 WARD)

2-FULL NAME Edward. Woll.

(a) RESIDENCE NO. 613 S. Ellwood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3 - 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Woll.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Julia Wagner.

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Joseph Woll.
(Address) 613 S. Ellwood Ave.

15 FEB 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1923.

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1923, to Feb 24, 1923, that I last saw h[illegible] alive on Feb 24, 1923, and that death occurred, on the date stated above, at 11.00 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. L. Burke, M. D.

, 19 (Address) 5072 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Feb. 26 1923

20 UNDERTAKER Lilly & Zeiler. ADDRESS 403 N Wolfe St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D73006 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 D73006

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE (No.) Bonds #126 (St.) Irvine Falls. 11 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary G. Ward-

(Residence in Baltimore: No. Labors Apts. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word): Single

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1877 (Year)

7-AGE: 46 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lady
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: Henry Ward

11-BIRTHPLACE OF FATHER, (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Henrietta Ward

13-BIRTHPLACE OF MOTHER, (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leslie Buckler

(Address) New York City

15- Filed FEB 26 1923 19?

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Feb. 23- 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning-

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Colton Stader M. D. (Coroner)

Feb 25 1923 (Address) 43 N. Bond

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Greenmount — DATE OF BURIAL: 2-26 1923

20-UNDERTAKER: Howard Jenkins Co — ADDRESS: Pulaski & Franklin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73007 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73007

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 Randall ST. 24 WARD)

2-FULL NAME Barbara E. Hartung

(a) RESIDENCE. NO. 500 Randall ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Ernest Hartung

6 DATE OF BIRTH (month, day, and year) May 15, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Co, Penna

PARENTS

10 NAME OF FATHER David Stiles

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Cristina Venus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Co. Penna

14 Informant Louise Klug, (Address) 500 Randall

15 FILED FEB 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from ~~Feb~~ 22, 1923, to Feb. 23, 1923, that I last saw h~~e~~r alive on Feb. 23, 1923, and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Wm. J. Seabury, M. D.

2/27 1923 (Address) 638 Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	2/26/23
20 UNDERTAKER	ADDRESS
S. J. Fahey & Sons	1318 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

Med 2162

D73008 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

10

CERTIFICATE OF DEATH.

D73008

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 N Lexington ST., 18 WARD)

2-FULL NAME Earl Robinson

(a) RESIDENCE NO. 1008 N Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city (State or country)

PARENTS

10 NAME OF FATHER John Robinson

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Martha Green

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Maggie Robinson (Address) 1008 N Lexington St

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-23-23, 19 , to 2-25-23, 19 ,

that I last saw h in alive on , 19

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) 3 yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Rachitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ed Cardozo, M. D.

2-26 1923 (Address) 1524 Hillsdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Cemetery

DATE OF BURIAL 2 27 1923

ADDRESS 1124

20 UNDERTAKER Forrow Hall

Mt Auburn

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Reported as positive Diphtheria from Laboratory Hosp.

Spec.—1-10-21—M&T—1500 Bks.

D73009

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D73009

101-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Park Ave. ST., 14 WARD)

2-FULL NAME Michael Sheehan

(a) RESIDENCE No. 1614 Park Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. -- mos. --- ds. How long in U. S., if of foreign birth? 73 yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Byrns

6 DATE OF BIRTH (month, day, and year) July 24, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) County Cork Ireland

PARENTS

10 NAME OF FATHER Timothy Sheehan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Johanna Bynche

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Jack Sheehan

(Address) 1614 Park Ave.

15 FEB 26 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1923, to Feb 24 1923.

that I last saw h alive on Feb 24, 1923.

and that death occurred, on the date stated above, at 10.20 P m.

The CAUSE OF DEATH* was as follows:

acute Lobar Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Jefferies Bunch M. D.

2/26 1923 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	2/27/23 19
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 Calvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D73010

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D73010

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., 25 WARD)

2-FULL NAME Mrs Mary Tyson

(a) RESIDENCE NO. Washington Blvd. ST., Halethorpe Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ga.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Self Mary Keyser

(Address) Halethorpe Md

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1923, to Feb 25, 1923, that I last saw h~~er~~ alive on Feb 25, 1923, and that death occurred, on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~Cause~~ Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Moses Emilson M. D.

, 19 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	2/27/23
20 UNDERTAKER	ADDRESS
Wm Addis Walker & Son	Lafayette Ave

Spec.—8-24-14—M. & T.—2000 Bks.

Gustav A Baglio ✓

D73011

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D73011

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 47 Rosemont Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gustave Baglio

(Residence in Baltimore: No. 47 Rosemont ave St.; 9 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) single

6-DATE OF BIRTH, June 4, 1913
(Month) (Day) (Year)

7-AGE, ...yrs. 8 mos. 19 ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ... none
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Eugene C Baglio

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Martha Snyder

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugene C Baglio

(Address) 47 Rosemont ave

15- FEB 26 1923 Filed ..., 191... ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 23, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 15 1923, to Feb 23 1923, that I saw him alive on ... 1923, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) ...yrs. ...mos. 10 ds.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs. ...mos. ...ds.

(Signed) Arthur O Dewes M. D.

Feb 24, 1923 (Address) 320 Cathedral

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery

DATE OF BURIAL, Feb 26, 1923

20-UNDERTAKER Jas C Miller

ADDRESS 2334 Jefferson St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D73012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73012

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 830 Pennington Ave ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frank Cermak

(a) RESIDENCE. NO. 830 Pennington Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs mos ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Cermak

6 DATE OF BIRTH (month, day, and year) May 16 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: John Cermak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Emma Zurek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): Frances Cermak 830 Pennington Ave

15. FEB 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 14 1923 to Feb 24 1923, that I last saw h— alive on Feb 24 1923, and that death occurred, on the date stated above, at 4.20 P.M.

The CAUSE OF DEATH* was as follows:

Pleurisy

(duration) A yrs. # mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) unknown

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Thos. B. Norton, M. D.

(Address) Curtis Bay, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. DATE OF BURIAL: Feb 27 1923

20 UNDERTAKER: Frank Enoch Son ADDRESS: Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

D73013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D73013

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Curry

(a) RESIDENCE NO. 2803 N. Calvert St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	78	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Arthur Curry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER Elizabeth Connelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md.

14 Informant Municipal Hospital Records.

(Address)

15 Filed FEB 26 1923 19... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23 19 23

17 I HEREBY CERTIFY, That I attended deceased from February 22 19 23 to February 23 19 23 that I last saw him alive on February 23 19 23 and that death occurred, on the date stated above, at 6:15 P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. McKown, M. D.

2-26-23 19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL 2/26 19 23

20 UNDERTAKER J. A. Moran & Bacon ADDRESS 3000

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D73014

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-00 D73014

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital Registered No. C.....

City of BALTIMORE: (No. 1104 E. Port St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Strowder

(Residence in Baltimore: No. 1104 E. Port St.; yrs., 5/4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	black	single

6-DATE OF BIRTH. (Month) 12 (Day) Feb (Year) 1907

7-AGE. 16 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: school- girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country.) Baltimore Md.

PARENTS.

10-NAME OF FATHER. Walter Strowder

11-BIRTHPLACE OF FATHER. (State or Country.) Va.

12-MAIDEN NAME OF MOTHER. Elizabeth Nash

13-BIRTHPLACE OF MOTHER. (State or Country.) Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Nash Strowder

(Address) 1104 N. port

15- Filed FEB 26 1923 By ROBERT R. KNAUER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Feb. 22/23 19.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Lymphatic Luekaemia

(autopsy at Hospital

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Sut Walker M. D. (Coroner)

2/24/23 (Address) 508 E. North AVE

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Ashley Cemetery DATE OF BURIAL. Feb 26 1923

20-UNDERTAKER. Mrs Robert A Elliott ADDRESS 1725- Ashland Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73015

16 D73015

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 W. 27th ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Turner

(a) RESIDENCE. NO. 311 W. 27th ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/24/20.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Clarence A. Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lorena Wolz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Clarence Turner (Address) 311 W. 27th St.

15 Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/24/, 1923, to 2/24/, 1923

that I last saw him alive on 2/24/, 1923

and that death occurred, on the date stated above, at 11.10 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia Prematurus

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Thomas F. Bluck M. D.

, 19 (Address) 457 E. 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem	Feb 26 1923
20 UNDERTAKER	ADDRESS
Jas. M. Funk Son	811 W. Lafayette

Spec.—1-10-21—M&T—1500 Bks.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73016 101-001 D73016

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 E. Mulberry ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Johnson

(a) RESIDENCE NO. 104 E. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Martha Johnson

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
37				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Fredericksburg Va.
(State or country)

PARENTS

10 NAME OF FATHER Ceazer Johnson

11 BIRTHPLACE OF FATHER (city or town) Fredericksburg
(State or country) Va

12 MAIDEN NAME OF MOTHER Mamie Johnson

13 BIRTHPLACE OF MOTHER (city or town) Fredericksburg
(State or country) Va.

14 Informant Martha Johnson
(Address)

15 Filed FEB 26 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-24- 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-21-, 1923, to 2-24-, 1923,

that I last saw h-- alive on 2-24-, 1923,

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Cassell, M. D.

2-25, 1923 (Address) 611 N. Carey.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetary

DATE OF BURIAL Feb 27 1923

20 UNDERTAKER Jos. T. H. Rochester

ADDRESS 1413 Jefferson

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

...c.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73017

CERTIFICATE OF DEATH.

5 31 D73017

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N. Eden ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madison Nelson

(Residence in Baltimore: No. 508 N. Eden St.; 25 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	C	Married

6-DATE OF BIRTH, unknown (Month) (Day) 1864 (Year)

7-AGE, 58 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer in oil
(b) General nature of industry, business, or establishment in which employed (or employer): Bird yard

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Luther Nelson (son)

(Address) 1420 McElderry St

15-

Filed FEB 26 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 25 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1922, to Feb 26 1923, that I saw him alive on Feb 23 1923, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Typhoid Fever on July 22

(Duration) ....yrs. 1 mos. ....ds.

(Signed) R. J. Young M. D.

2/26, 1923. (Address) 1429 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Middle River Cemetery — DATE OF BURIAL, Feb. 28, 1923

20-UNDERTAKER for I. H. Rochester — ADDRESS 1413 Jefferson

D73018

HEALTH DEPARTMENT—CITY OF BALTIMORE

D73018

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Kaminkow

(Residence in Baltimore: No. 833 N Gilmor St. (yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	widow

6-DATE OF BIRTH. Unknown (Month) (Day) 1847 (Year)

7-AGE. 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elke Kaminkow

(Address) 833 N. Gilmor St

15- Filed FEB 26 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 25 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jurors (Inquest, autopsy or inquiry.) find that said deceased came to their death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of both femurs
Subdural Hemorrhage
accident by falling down
Stairway Room to Basement (Duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) James M. Reuben M. D. (Coroner.)

Feb 26 1923 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents.) At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 833 N. Gilmor St

Former or usual residence 833 N Gilmor St

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rodph Ch DATE OF BURIAL, 2-26 1923

20-UNDERTAKER, Jack Lewis ADDRESS 1439 E Balto St

IS VERY IMPORTANT. See instructions on back of certificate.

Spec. —H. P. Co.—1000 Rks.

HEALTH DE

D73019

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 218 N. [illegible]

2-FULL NAME George Wells [illegible]

(a) RESIDENCE. No. 218 N Lite[illegible]
(Usual place of abode)
Length of residence in city or town where death occurred ____ yrs.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Harold C. Simmons

11 BIRTHPLACE OF FATHER (city or town) Windsor
(State or country) Conn

12 MAIDEN NAME OF MOTHER Dora B. Jennings

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Harold C. Simmons
(Address) 218 N Lite[illegible]

15 FEB 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

that I last
and that death occurred
The CAUSE OF DEATH

Bronch[illegible]

(dura[illegible]

CONTRIBUTORY (Secondary) [illegible]
(duration)

18 Where was disease contracted if not at place of death? at H[illegible]

Did an operation precede death? no D[illegible]

Was there an autopsy? no

What test confirmed diagnosis? Visual

(Signed) C. M. Coff

2[illegible] 19 2 (Address) 1107 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent state (1) Means and Nature of Injury, and (2) whether Acci Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park[illegible]

DATE OF BURIAL: Feb 15 2

20 UNDERTAKER: Detmold Bros

ADDRESS: 1723 W Lafa[illegible]

...E.—WRITE PLAINLY, WITH UNFADING INK ... A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may ... part of the second statement. Never return ... "Foreman," "Manager," "Dealer," etc., ... precise specification, as *Day laborer, ... mine, etc.* Women at ... es of the household ... eive a definite ... *Housework*. ... mployed, as ... taken to ... engaged ... *Cook*, ... anged ... DEATH. ... retired ... thus:

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary.